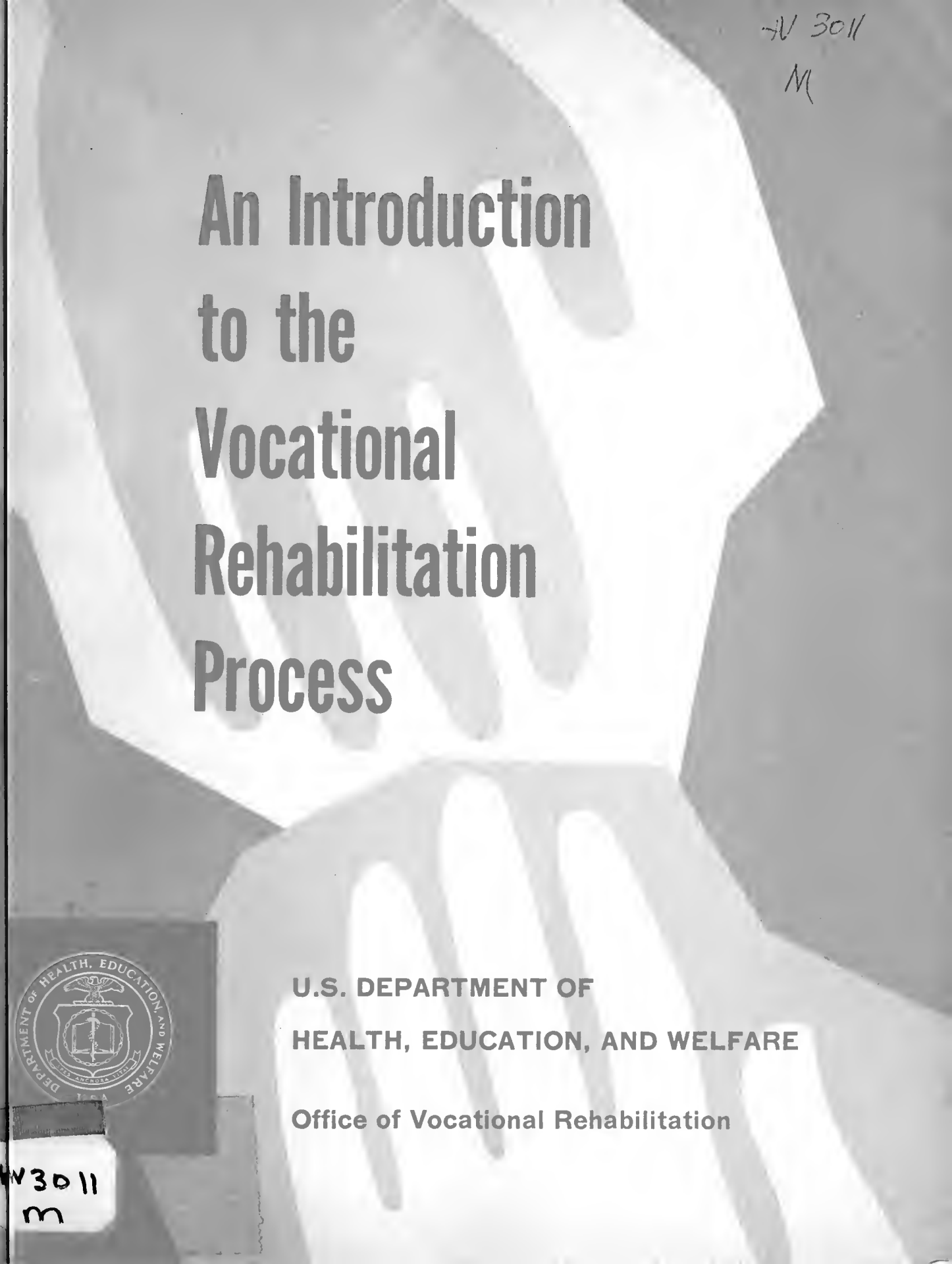
An Introduction to the Vocational Rehabilitation Process



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Office of Vocational Rehabilitation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AN INTRODUCTION

to the

VOCATIONAL REHABILITATION PROCESS

A Manual for
Orientation and In-Service Training

Compiled from

Proceedings of Guidance, Training, and Placement Workshops

Orientation Training Syllabus for Vocational Rehabilitation Counselors

and the

Gatlinburg Workshop

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Vocational Rehabilitation

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THE VOCATIONAL REHABILITATION PROCESS

Extent of Disability

Organization to Meet Needs

Basic Concepts

History and Legal Basis

Counselor's Functions

Identification of Persons in Need

Rehabilitation Client-Study Process

Client Services

Administrative Duties

Counseling Problems and Techniques

The Professional Counselor

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FOREWORD

State vocational rehabilitation agencies provide in their State Plans for a program of staff development for their personnel. This program provides for in-service training to develop a high quality of vocational rehabilitation services to handicapped persons. In many States the staff development program includes leaves of absence for institutional or other organized training for professional staff members. In all States provision is made for a program of orientation training at the regional and/or State levels. The Council of State Directors of Vocational Rehabilitation, in cooperation with the Office of Vocational Rehabilitation, has recommended the following objectives of orientation training:

> To provide the worker with an understanding and appreciation of the broad principles and philosophy of vocational rehabilitation.
>
> To acquaint the worker with the historical background of the vocational rehabilitation program, its legal basis, its regulations and policies.
>
> To assure the worker of a thorough understanding of his responsibilities and duties in relation to the agency's program and procedures; and to acquaint the worker with the knowledge of the skills required for the effective performance of his job.
>
> To acquaint the worker with resources and facilities available to him for supervision, consultation, and client services.
>
> To stimulate in the worker a feeling of "belonging" to a professional group that functions cooperatively in serving handicapped individuals.
>
> To make the worker aware of the need for continuous professional growth and development in order to keep abreast of the best methods and techniques in vocational rehabilitation.

The Vocational Rehabilitation Act (Section 7) provides that the Secretary of Health, Education, and Welfare shall "cooperate with and render technical assistance to States in matters relating to the vocational rehabilitation of physically handicapped individuals" and shall "provide short-term training and instruction in technical matters relating to vocational rehabilitation services...."

This publication, the third in a series of bulletins, has been prepared to provide technical instructional materials, so that the State agencies and OVR may better carry out their staff development responsibilities. It is hoped that it will be used widely in various rehabilitation situations and settings.

The materials in this publication do not necessarily represent the official views of the Office of Vocational Rehabilitation nor of State vocational rehabilitation agencies, and do not have the effect of law, regulation, or ruling. They do, however, reflect efforts by State vocational rehabilitation workers and OVR consultants to explore significant aspects of programs in order to encourage evaluation and stimulate professional growth.

Joseph Hunt
Assistant Director
Office of Vocational Rehabilitation

PREFACE

The purpose of this Manual is to provide training material which can be used for the orientation of new counselors as well as for the in-service training of more experienced rehabilitation counseling personnel.

The Manual was originally published in syllabus form in 1955, following the enactment of Public Law 565 in 1954. At that time funds had become available which would allow the States, in anticipation of greatly increased rehabilitation services, to increase the size of their counseling staffs. With the influx of new counselors which followed there arose an immediate need for the establishment of a new series of regional orientation training institutes throughout the country. Prior to the preparation of the Manual a committee of the Council of State Directors of Vocational Rehabilitation met in Washington, D. C. for the purpose of advising the Office of Vocational Rehabilitation on the objectives and content of these proposed institutes.

In line with their recommendations, staff members of the Office of Vocational Rehabilitation prepared material covering the topics suggested. Much of the material had been developed by previous sessions of the Guidance, Training and Placement Workshops and merely needed revision, while other parts of it represented original writings by various staff members. This material was published in multilith form in October 1955, in time for the first of a new series of orientation training institutes, under the title Orientation Training for Vocational Rehabilitation Counselors, a Syllabus for Orientation Institutes. Since twelve different staff members contributed to its preparation and very little time was available for refined editing by any one person, the syllabus was found to contain a certain amount of unnecessary overlap and repetition, and some confusion as to the order of presentation, with a resulting loss of continuity.

In an attempt to correct some of these faults, a workshop was called at Gatlinburg, Tennessee, in September 1957, under the sponsorship of the Richmond Professional Institute. Attending this workshop were the following: Mrs. Katherine P. Cavell (Michigan); James C. Gardner, M. D. (Tennessee); Douglas MacFarland, Ph. D. (Virginia); Miss Adaline Johnesse (OVR); Miss Marion Martin (New York); Mr. Alfred McCauley (West Virginia); Mr. Shelton W. McLelland (OVR); Mr. Edgar B. Porter (OVR); Mr. O. E. Reece (Tennessee); Cecil Samuelson, Ph. D. (Utah); Mr. J. Hank Smith (Tennessee); Wade O. Stalnaker, Ph. D. (Virginia); James H. Stewart, M. D. (Oregon); and Bruce Thomason, Ph. D. (Florida). As a result of the workshop, the Manual was reorganized and certain parts were either revised or rewritten.

In June 1959, the College of Education, University of Missouri, was given a small grant to complete a final revision of the manuscript under the editorship of John F. McGowan. The revision consisted of adding a bibliography, case study material to go with Part II of the Manual, rewriting of entire chapters to eliminate extensive outlining and differences and style, and finally writing several new chapters to complete the Manual.

The purpose of the case study abstracts is to provide those who use the Manual with a ready source of practical and realistic case material. It is hoped that this material will relate the information contained in each one of the sections to the day-by-day activities, problems, and duties of the counselor, thus making the learning more real and permanent.

During the revision of the Manual the editor worked closely with the OVR staff in Washington. He attended the Thirteenth Annual Guidance, Training and Placement Workshop in Washington where he served as consultant to the sub-committee on the training of new counselors. The recommendations of the committee, which appear in the Appendix, provide an outline for the orientation and in-service training of rehabilitation counseling staffs. It was the recommendation of this committee that certain training material related to counselor needs can best be presented in scheduled regional orientation training institutes coordinated by the OVR Regional Representatives, or at regularly scheduled in-service courses within the State. As a general rule, such regional training meetings should include materials designed to produce and develop broad understandings, background knowledges, and general concepts. On the other hand, materials and experiences aimed at developing specific skills and job effectiveness related to professional competencies are generally best provided at the State level. This Manual contains material which will help develop the broad understandings, background knowledges, and general concepts outlined above, but each State will still need to prepare supplemental material.

Acknowledgement is made to four graduate students who participated in the revision. They are Mr. William Phelps, Mr. Richard Thoreson, Mr. Bob G. Johnson, and Mr. Robert Heaberlin. Mr. Robert Prouty, of the University's staff, also worked on the final revision. With his years of experiences as a rehabilitation counselor he was a great help in preparing the case study material.

Special thanks are due Mr. Edgar B. Porter, Consultant, Staff Development, Office of Vocational Rehabilitation, who initiated the revision of the original publication and coordinated the entire project.

John F. McGowan

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PART ONE

INTRODUCTION AND BACKGROUND

The problems of the disabled members of our society are of interest and importance to the people of America. In recent years, medicine and related medical sciences have made great advances in knowledges and techniques and marked improvements in their services. One of the results of these improved services is that individuals who might previously have died, or have been severely disabled, are now treated and returned to society. Nevertheless, many of these people have residuals of disease or illness which prevent them from returning to the occupation in which they had previously made their living and are in need of rehabilitation services.

Another problem which is now being created as a result of our scientific and medical progress is related to the increased percent of our total population who fall within the "old age" category. Many of these people now being retired might not be able to do work involving heavy energy expenditure, but can do many types of lighter work if properly guided and rehabilitated. Social security laws and regulations are continuously studied and their services are being integrated more closely with programs of vocational rehabilitation throughout the country. Rehabilitation counselors are working closely with the schools, especially the field of special education, to encourage handicapped youth to benefit from the rehabilitation services which are now available.

The purpose of this introduction to rehabilitation will be to provide an overall view of the current status of the field, to review traditional attitudes and beliefs about the handicapped, and to outline the philosophy underlying the current emphasis now being given to the rehabilitation movement in America.

Previous Attitudes Regarding Illness

Studies of the history of the handicapped of previous societies show that their fellowmen have fluctuated from one end of the continuum to the other in their attitude and feeling towards the handicapped or crippled members of their community. In one society we find that they are regarded as close to God or Godlike while on the other they were considered as tools of the devil who should be destroyed. Theophrustus (14) writing in the Fourth Century A.D. states that when a person "sees a madman or epileptic he shudders and spits in his bosom." To the ancient Hebrew, illness and physical defect often marked the person as a sinner. (14)

In ancient Greece, a disease was seen as a heinous thing, indicative of inferiority. (14) Standing in contrast to these ideas is the strict scientific viewpoint which classifies disease as a physical consequence of amoral natural conditions many of which can be understood and often controlled.

Attitudes concerning the disabled in American Society, as expressed in humor, reveal the derogatory view taken by the general population

toward physical abnormalities. Barker et al, (2) found in their analysis of five collections including nearly seven thousand jokes that four percent were concerned with persons having physical defects and eighty percent of these jokes clearly depreciated disabled persons. In contrast with this, farmers, salesmen, judges and dentists as subjects of jokes were depreciated in but forty-nine percent of the examples.

The fact that widespread prejudice toward the handicapped exists in many areas seems to be well established. Meng (4) attributes such prejudice toward the handicapped by the non-handicapped in modern society to three deep and often unconscious mechanisms--(a) a belief that physical abnormality is a retribution for evil, and hence the disabled person is evil and dangerous; (b) a belief that a disabled person has been unjustly punished and is therefore under compulsion to do an evil act to balance the injustice, and hence that he is dangerous; (c) the projection of one's own unacceptable impulses upon the disabled, and hence that he is evil and dangerous.

Gellman (4) asserts that prejudice toward handicapped persons is prevalent at all socio-economic levels and in all regions of our country. He believes that the roots of prejudice are formed out of (a) social customs and norms, (b) child-rearing practices which stress normalcy and health, (c) the reawakening of neurotic childhood fears in frustrating or anxiety provoking situations and (d) prejudices by invitation-discrimination provoking behavior by the disabled.

The rehabilitation counselor and members of related professions may feel that they are beyond the pressure of the traditional prejudices of society by virtue of their close helping relationships with the handicapped; however, those who have made a critical analysis of the total dynamics of the rehabilitation process see factors which often mitigate against full acceptance and complete objectivity. Some of the factors operating which tend to color the handicapped individual's perception of rehabilitation would include (a) his present social role as an inferior, helpless person, (b) his lowly position in the status hierarchy of most agencies, (c) the tendency for some counselors to assume an omnipotent role, and (d) the prevailing middle-class orientation of rehabilitation personnel which serves to increase social distance. (4)

Rehabilitation in Contemporary American Society

The emergence of vocational rehabilitation as a social force in modern times has its roots deep in the goals of society. A growing awareness of the intrinsic dignity of man has led to the concept that manpower is a precious resource, not to be treated wastefully, but to be utilized effectively and productively. The firmly established status of guidance in America's schools reflects the belief that an individual should be given maximum opportunity for the development of his potentialities. A primary goal of vocational rehabilitation is to uncover these interests, aptitudes, values and aspirations of the individual as they relate to vocational assets.

It is perfectly acceptable to speak of the underlying humanitarian base of the vocational rehabilitation movement, but it should not obscure from view the practical fact that the Federal-State rehabilitation program must prove economically sound in order to justify its existence. In essence, one of the purposes of a formally established program of rehabilitation is to save money by making the individual capable of self-support. The Federal legislative provisions have provided the impetus for removal of disabled persons from relief rolls by helping them become not only self-supporting, but contributing.

In America, our school system and our entire way of life are based upon the assumptions that every individual has the right of life, liberty and the pursuit of happiness as guaranteed in our Constitution, and that these rights of the individual impose a corresponding obligation upon the State to provide those necessary services which will allow all, not just part, of its citizens to reach a satisfactory level of personal productivity.

Studies of employer attitudes and practices in hiring the disabled demonstrate the need for a great deal of general re-education. In actual practice, many employers do not employ workers with appreciable disability except when the labor market is tight (2). Many workers in the field are of the opinion that the highly coercive role of the employer as a person who produces the most goods at the lowest possible cost, while at the same time maintaining a position of high standing in the community, imposes on the employer an unverbalized conception of what makes up a "good" worker. Through exclusion of the physically disabled, the employer may believe that he enhances his opportunity of obtaining workers who demonstrate qualities of adaptability, stamina, quickness, interest, cooperativeness, job stability, and at low cost.

Barker et al (2) suggest that in the light of the widespread resistance toward hiring the handicapped, the extensive promotional campaigns of public and private organizations advancing the idea that the handicapped are, in actuality, desirable employees, may in fact have the opposite effect of intensifying negative employer attitudes by virtue of their protesting too much. It is evident that placement of the handicapped in industry on a charity basis is unlikely to succeed. A greater probability of success is assured through a sound understanding of the positive assets of the client which indicate that his job performance will be comparable to, or surpass that of a non-handicapped individual on the same job.

Tremendous expansion in rehabilitation services and facilities has taken place in recent years. From its beginning in 1920 and continuing for twenty-three years the scope of the Federal-State rehabilitation program was limited. In 1943 it received its first substantial boost through the Barden-LaFollette Act, and in 1954 received the substantial support of both the President and the Congress for the new amendments. The provisions of this Act will be discussed in detail later.

Overview of Rehabilitation

Vocational rehabilitation counseling may be defined as a process in which a counselor thinks and works in a face to face situation with a disabled person in order to help him understand both his problems and his potentialities, and to carry through a program of adjustment and self improvement to the end that he will make the best obtainable vocational, personal and social adjustment. The job of the rehabilitation counselor is to help the handicapped person maximize his vocational potentialities. The term "process" provides the appropriate frame of reference for vocational rehabilitation insofar as it can convey the idea that vocational rehabilitation is an on-going dynamic process in which interaction between the client and counselor facilitates improvement in client self-understanding and effective utilization of his positive vocational assets.

The vocational rehabilitation counselor offers help to those individuals whose handicapping condition occurred prior to significant work experience (habilitation) and to those who engaged in gainful employment before acquiring a vocational handicap (rehabilitation).

A handicapped person facing the realities of the world-of-work may require assistance from a State vocational rehabilitation agency. Should he choose to seek help, there would be certain basic requirements to be met. His eligibility for service would be based upon (1) the presence of a physical or mental disability and the resulting functional limitation or limitations in activities; (2) existence of a substantial handicap to employment caused by the limitations resulting from his disability; (3) a reasonable expectation that vocational rehabilitation services may render him fit to engage in a remunerative occupation. Meeting of the first requirement is determined through a general medical examination and specialists' examinations if necessary. The second and third fall essentially within the counselor's area of specialty and are determined during the total diagnostic procedures.

Age and residence requirements, which vary somewhat from State to State, also enter into the eligibility picture. Generally, the handicapped person must be considered a permanent resident of the State and in most States must have reached his sixteenth birthday by the time he becomes ready for employment.

Once the handicapped individual has been found eligible for vocational rehabilitation, the services needed for his rehabilitation must be considered. The basic services offered by a State vocational rehabilitation agency fall into two categories: those usually provided regardless of financial status--counseling, training and placement, and those provided which are dependent on the demonstrated economic need of the handicapped individual--physical restoration, maintenance, transportation, books and supplies, tools and equipment, occupational licenses and other goods and services. The counselor has the responsibility for assuring that all necessary services are provided for in the total rehabilitation plan.

Counseling is often spoken of as forming the core of the rehabilitation process and as the most substantial service offered by a State agency. In the manual Rehabilitation Counselor Preparation (5) which was prepared by participants at the Charlottesville Workshop and published jointly by the National Rehabilitation Association and the National Vocational Guidance Association in 1956, is found the following statement "The core of the rehabilitation counselor's work is counseling. He accomplishes this function by establishing and maintaining a counseling relationship, which serves to unify all the rehabilitation services into an organized plan resulting in an integrated experience. The counselor helps the disabled individual evaluate his assets and liabilities, understand his problems and the steps necessary to resolve him."

In the manual, Casework Performance in Vocational Rehabilitation (12) edited by Thomason and Barrett reflecting the feelings of the participants in previous Guidance, Training and Placement Workshops, is found the following statement: "Counseling is the one activity which pervades the entire process of vocational rehabilitation. It starts at the initial interview with the client, and continues until a satisfactory job adjustment has been achieved."

The vocational rehabilitation movement is now going through a period of unprecedented growth and expansion. Rehabilitation as an affirmation of human worth and as a conservation of human resources has a vital role to play. Problems, assuredly, have arisen as a result of this growth. Some workers and disciplines have tended to eye with suspicion anything that intrudes upon their closely-knit rehabilitation family. (6)

Some writers have deplored the interprofessional jealousy that develops as one specialty sees its domain encroached upon by another (7). Physicians may occasionally feel threatened by psychologists and rehabilitation counselors. Social workers may occasionally feel threatened by rehabilitation counselors, and vice versa. Education, psychology and social work all rigorously insist on their claim as the rightful parents of the rehabilitation counselor. (7)

Perhaps the main concern, at the present time, is that the handicapped individual not be lost in the shuffle. Our general techniques for the treatment of handicapping conditions, and our over-all knowledge of and sophistication toward rehabilitation problems have shown marked progress in the past decade. The medical profession has seen the need for the designation of a medical specialty--physiatry, to signify the newly gained understandings in physical medicine and rehabilitation. There has been a rapid upswing in professional literature concerning all phases of rehabilitation. Funds appropriated for research in rehabilitation are now beginning to bear fruit with the result that professional workers in rehabilitation have a much wider array of useful knowledge to draw from.

Waldrop (15) writing on the current status of rehabilitation suggests that there is new hope for the disabled physically, socially and psychologically. Better training, professional development, more

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imaginative treatment concepts, and enlightened cultural concern mean a brighter future for the handicapped. Rehabilitation born small and obscure has come of age in the mid-twentieth century.

References and Suggested Readings

1. Anderson, R. P., "The Rehabilitation Counselor as Counselor." J. of Rehabilitation, 1958, 14 (2), 4-5:18.

2. Barker, R., et al. Adjustment to Physical Handicap and Illness; a survey of the social psychology of physique and disability. New York: Social Science Research Council, 1953.

3. Cantrell, Dorothy., "Training the Rehabilitation Counselor." Personnel Guidance J., 1958, 6, 382-387.

4. Gellman, W., "Roots of Prejudice Against the Handicapped." J. of Rehabilitation, 1959, 25 (1), 4-6:25.

5. Hall, J. H., and Warren, S. L. (Eds.) Rehabilitation Counselor Preparation. Washington: National Rehabilitation Assn., 1956.

6. Hunt, Joseph, "The Rehabilitation Counselor and the Future." J. of Rehabilitation, 14 (5), 4-7; 15.

7. Mathewson, R. H., Shoben, E. J., Jr. and Mitchell, H. E., "Symposium on Interprofessional Relations," J. of Counsel. Psychology, 1955, 2 (3), 196-204.

8. Patterson, C. H., "Counselor or Coordinator?" J. of Rehabilitation, 1957, 3 (3), 13-15.

9. Patterson, C. H., Counseling the Emotionally Disturbed. New York: Harper, 1958.

10. Pattison, H. A. (Ed.), The Handicapped and Their Rehabilitation. Springfield, Ill.: Charles C. Thomas, 1957.

11. Rosse, A. A., and Peters, J. S. II., "Rehabilitation Counselors in Public Agencies." Personnel Guidance J., 1958, 7, 486-488.

12. Thomason, B., and Barrett, A. M. (Eds.) Casework Performance in Vocational Rehabilitation. Washington: U. S. Department of Health, Education and Welfare, 1959.

13. Tickton, S. G., Rebuilding Human Lives: the rehabilitation of the handicapped, Part One, Trained rehabilitation workers: how much are they paid? New York, The Seventh Co., Inc., 1957.

14. Theophrustus., The Characters of Theophrustus, Edited and translated by J. M. Edmonds, Loeb Classical Library, 1929, p. 82. cited by O. Temkin, The Falling Sickness, Baltimore: Johns Hopkins Press, 1945, p. 7.

15. Waldrop, R. S., "Signs of the Time in Rehabilitation." J. of Rehabilitation, 1959, 15 (2), 4-5; 44-48.

In rehabilitation, as in medical and other related fields, one of the problems encountered has been the lack of up-to-date information on the number and characteristics of persons with chronic diseases and impairments. However, under legislation enacted by Congress in the summer of 1956, a continuing National Health Survey was inaugurated by the Public Health Service starting in July 1957, to provide current data, on a regular basis, on the health status of the general population.

Present estimates from the ongoing National Health Survey (24) indicate that more than 40 percent of the men, women, and children in the United States have some chronic illness or impairment. This would be equivalent to nearly 70 million persons not including those in institutions. By no means all of these are seriously handicapped or disabled in the sense of being limited in their ability to lead fairly normal lives.

An estimated 13½ million of these persons are limited in the amount or kind of activity they are able to perform, while an additional 3½ million are totally unable to carry on their major activity--working, keeping house, or attending school--because of their disability. This group includes 1 million who are homebound.

In all, an estimated 10 percent of the population living outside of institutions have some degree of long-term limitation of activity due to chronic illness or impairment, ranging from 1 or 2 percent among persons under 15 years of age to 55 percent among those 75 and older.

Chronic limitation of activity is most prevalent among the low-income families. Approximately 21 percent of persons in families with income less than $2,000 per year had some degree of chronic limitation of activity. This proportion decreased steadily down to only 7 percent with activity limitation in families with income of $7,000 or more.

Current information on the causes of chronic illness and impairments among persons living outside of institutions is becoming available through the on-going National Health Survey (27, 28, 29). However, for a few more years the 1935-36 National Health Survey will continue to be the most comprehensive source of data on these conditions. Findings from this older survey (30) indicate that diseases are the causes in the majority of cases. It is roughly estimated that diseases are the cause in about 88 percent of the cases, and that congenital conditions account for about 2 percent of the cases. Some of the major diseases from the standpoint of the relative number of persons disabled by them are the cardiovascular-renal diseases; nervous and mental diseases; arthritis; rheumatism, and related disease; tuberculosis; and blindness.

Various estimates have been made of the number of persons with different types of conditions, including the non-disabled as well as the disabled. For example, estimates are available for the number of persons

with orthopedic impairments, cardio-vascular-renal diseases (there is also a separate estimate for the number of heart disease), arthritis, blindness, deafness or impaired hearing, tuberculosis, cerebral palsy, and epilepsy. These estimates vary greatly in reliability. They include persons of all ages (for some conditions an age breakdown is available). They are not additive since a person may have two or more different diseases or impairments, or might be included in two different groups on the basis of the same conditions--for example, persons paralyzed from poliomyelitis and many persons with arthritis would also be included among those with orthopedic impairments. The estimates are for the Nation as a whole, and only for the number of blind are estimates available for the different States (3, 7, 8, 9, 26, 27, 28, 29).

Disability as a Social and Economic Problem

Disability is one of the important causes of dependency. It is not known how many disabled persons are self-supporting--living on savings, income from savings or investments, private or union pensions, private disability or other insurance payments, etc. Neither is information available as to the number of disabled persons who are supported wholly or in part by their families, relatives, friends, or private, social charitable and religious agencies. The problem is apparent, however, in terms of public assistance. Estimates indicate that at the end of 1958 about 1,317,000 persons under age 65 were receiving public assistance because of the disability of either the recipient or the family breadwinner. About 552,000 of these were dependent children who were in need because of the disability of one or both parents. The cost in Federal, State, and local funds for assistance to or on behalf of these persons was as estimated $681 million annually. These estimates include persons receiving general assistance but exclude those on old-age assistance (5, 22).

Disability reduces productivity and is a drain on the wealth of the community, the State, and the nation as a whole. The effect of disability on the manpower resources of the nation is for the most part concentrated in the 14-64 year age group. It has been estimated that roughly 75 percent (2.2 million) of the 2.9 million persons, aged 14-64, with disabilities lasting more than six months would have been in the labor force if they were not disabled. The remainder of the group are persons who if not disabled would have been engaged in keeping house, going to school, or some other activity other than gainful employment. Disability not only prevents people from working and receiving an income, thus contributing to the productivity and purchasing power of the community, but it requires taxes and voluntary contributions to carry on the programs needed to help maintain disabled persons who are in need (21, 22).

Disability affects the life of the family as well as that of the individual. The disabled individual frequently experiences a deterioration of his basic skills, he loses his self-confidence, and becomes despondent. Frequently unable to participate in the normal life of the family and the community, he may become maladjusted because of a feeling of inequality, lack of prestige, and other concomitants of "not belonging." If there is

a disabled individual in the family, it also may affect the whole family life. Someone may have to give up working to care for the disabled individual. The social life of others in the family may have to be adjusted so there is someone in constant attendance. Frequently the disabled individual may have to leave home and go to an institution for long-term care, separating him from his family and breaking up the family unit. It is estimated that there are almost 1.2 million disabled persons in institutions for long-term care (6, 22).

With our population increasing in size and proportion of older persons, the overall prevalence and incidence of chronic diseases and disability increase rather rapidly with age. The overall affect of advances in medical science is somewhat difficult to assess--modern medicine extends the life span of many sick and disabled persons, but for many others it can prevent the disabling effects of diseases or accidents. In the past, adequate periodic studies have not been made from which to measure the trend over the years. The new continuing National Health Survey, however will make such analyses possible. (2, 4, 8, 11, 12, 14, 15, 17, 24, 25, 27)

The trend has been for an increased need for more hospitals and other facilities for the treatment and care of disabled persons, more personnel to provide the services necessary to reduce and prevent disability, the development of more education and training opportunities for disabled persons, and the development of more job opportunities. This increasing need is no doubt due to a number of factors--the increased number of disabled persons requiring help, the increase in our knowledge of what can be done for them, and the growing recognition of disability as a social economic problem which is of concern to society as a whole (12, 17, 18, 22).

Meeting the Needs of Disabled Persons

There are a number of public and private programs which provide various types of help for disabled persons--some of them designed specifically to meet their needs. Included are the Federally-aided programs of vocational rehabilitation, Aid to the Blind, Aid to the Permanently and Totally Disabled, Aid to Dependent Children, Old-Age Assistance, and Services for Crippled Children. Other public programs include Workmen's Compensation, State temporary disability insurance programs in several States, and the Old-Age and Survivors Insurance Disability Program. The various private and voluntary programs are too numerous to mention (3, 10, 12, 16, 17, 18, 19, 20).

Most people with chronic diseases or impairments are not sufficiently handicapped to require the special services of vocational rehabilitation in order to work and not all disabled persons would be able to profit from such services. There are, however, an estimated 2,150,000 persons in the United States today who need special help in order to do productive work, and therefore come within the scope of the State-Federal program of vocational rehabilitation.

This estimate represents the number of persons 14 years of age and over, having a chronic disease or physical or mental impairment that constitutes a substantial handicap to employment. It relates to persons with disabilities that are long-term rather than temporary in nature, yet it does not include those persons with conditions that are so serious or of such a nature that there is little chance to rehabilitate them for work. Built up over a period of years as our population has increased and aged and needs not met on a current basis - the group of 2,150,000 is now, from year-to-year, a relatively stable group. However, it is not a static group. It includes an estimated 270,000 persons who within the year have come to need vocational rehabilitation services--roughly taking the place of those who complete their rehabilitation under the State-Federal program, those who become suitably employed through the help of some other agency or organization or through their own efforts, those who become too severely disabled to benefit from services or so old that placement is impossible, those who die, and those who for a number of other reasons, no longer need services (13,31).

On June 30, 1959, the close of the 1959 fiscal year, a total of 171,111 cases were in the active load of the State vocational rehabilitation agencies, about 8 percent more than at the close of the 1958 fiscal year. A total of 80,739 persons were rehabilitated during the fiscal year and their cases closed. This was 9 percent more than the 74,317 rehabilitated during the previous fiscal year. In addition to the cases in the active load, there were 122,835 "referrals" on hand on June 30, 1959--2 percent more than were on hand the year before. "Referrals" are persons whose cases are being or have not yet been investigated and a decision has not yet been made as to whether or not the individual can be accepted for vocational rehabilitation services. Similar data are available for each fiscal year (1).

References and Suggested Readings

1. Annual Reports of the U. S. Department of Health, Education and Welfare, Office of Vocational Rehabilitation.

2. Britten, Rollo H., Collins, Selwyn D., and Fitzgerald, James S., "The National Health Survey, Some General Findings as to Disease, Accidents, and Impairments in Urban Areas," Public Health Reports 55: 444-470, March 15, 1940.

3. Chronic Illness in the United States, Volume II, Care of the Long-Term Patient. Commission of Chronic Illness. Published for the Commonwealth Fund by Harvard University Press, 1956.

4. Estimated Prevalence of Long-Term Disability, 1954, Social Security Bulletin, 18: 20-21, June 1955.

5. Estimates of Disability Among Public Assistance Recipients Under Age 65, End of Fiscal Year 1958, Estimates prepared by the Division of Program Statistics and Analysis, Bureau of Public Assistance, for the Division of Program Statistics and Special Studies, Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare, Washington, D. C.

6. Garrett, James F., (Ed.), Psychological Aspects of Physical Disability, Rehabilitation Service Series Number 210, Federal Security Agency (now the Department of Health, Education, and Welfare), Office of Vocational Rehabilitation, Washington, D. C.

7. Glaser, Stanley, Trauger, Donald A., and Wyman, Arthur H., "Estimate of Tuberculosis Prevalence in the United States, 1956, Public Health Reports, 72: 963-968, November 1957.

8. Hurlin, Ralph G.,"Estimated Prevalence of Blindness in the United States." July 1952, Social Security Bulletin. 16: 8-11, 24 July 1953.

9. Karpinos, Bernard D.,"The Physically Handicapped," Public Health Reports. 58: 1573-1592, October 22, 1943.

10. McCamman, Dorothy and Skolnik, Alfred M.,"Workmen's Compensation: Measures of Accomplishment." Social Security Bulletin. 17: 3-13, March 1954.

11. Moore, Marjorie E., and Sanders, Berkev S., "Extent of Total Disability in the United States." Social Security Bulletin. 13:7 - 14, November 1950.

12. New Hope for the Disabled, U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation.

13. Number of Disabled Persons in Need of Vocational Rehabilitation. Rehabilitation Service Series Number 274, U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, Division of Research and Statistics, Washington, D. C. June 1954.

14. Perrott, G. St. J., Smith, Lucille M., Pennell, Maryland Y., and Altenderfer, Marion E., "Care of the Long-Term Patient," A Source Book on Size and Characteristics of the Problem, Public Health Service Publication No. 344, U. S. Department of Health, Education, and Welfare, Public Health Service, February 1954.

15. Sanders, Berkev S., and Moore, Marjorie E., Estimates of the Prevalence of Disability in the United States. September 1950, Rehabilitation Service Series Number 317, U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, April 1955.

16. Schottland, Charles I., "The Social Security Act: The First Twenty Years," and related articles by others. Social Security Bulletin. 18: 1-32, August 1955.

17. Schottland, Charles I.,"Trends Affecting Public and Voluntary Social Welfare Planning. Social Security Bulletin. 18: 3-6, February 1955.

18. Schottland, Charles I., "Toward Greater Security in Childhood." Social Security Bulletin. 18: 3-7, April 1955.

19. Schottland, Charles I.,"Social Security Amendments of 1956: A Summary and Legislative History." Social Security Bulletin. 19: 3-15, 31, September 1956.

20. Skolnik, Alfred M., "Temporary Disability Insurance Laws in the United States." Social Security Bulletin. 15: 11-22, October 1952.

21. Stecker, Margaret L., "Why Do Beneficiaries Retire? Who Among Them Return to Work?" Social Security Bulletin. 18: 3-12, 35-36, May 1955.

22. Switzer, Mary E. and Rusk, Howard A., "Doing Something for the Disabled." Public Affairs Pamphlet No. 197, with the Cooperation of the National Rehabilitation Association, May 1959.

23. Task Force on the Handicapped, Report of, to the Chairman, Manpower Policy Committee, Office of Defense Mobilization, Washington, D. C.

24. Limitation of Activity and Mobility due to Chronic Conditions, United States, July 1957 - June 1958, PHS Publication No. 584-B-11. Washington, D. C., Government Printing Office 1959.

25. Woolsey, Theodore D., "Estimates of Disabling Illness Prevalence in the United States." Public Health Monograph Number 4, Public Health Service Publication Number 181, Federal Security Agency (now U. S. Department of Health, Education, and Welfare), Public Health Service, August 1952.

26. Woolsey, Theodore D., "Prevalence of Arthritis and Rheumatism in the United States." Public Health Reports. 67: 505-512, June 1952.

27. Impairments by Type, Sex and Age, United States, July 1957-June 1958. PHS Publication Number 584-B-9, Washington, D. C., Government Printing Office, 1959.

28. Chronic Respiratory Conditions Reported in Interviews, United States, July 1957 - June 1958. PHS Publication No. 584-B-12, Washington, D. C., Government Printing Office, 1959.

29. Heart Conditions and High Blood Pressure Reported in Interviews, United States, July 1957-June 1958. PHS Publication Number 584-B-13, Washington, D. C., Government Printing Office, 1960.

30. Britten, Rollo H., Collins, Selwyn D., and Fitzgerald, James S., "The National Health Survey, Some General Findings as to Disease, Accident, and Impairments in Urban Areas." Public Health Reports, 55: 444-470, March 15, 1940.

31. Hunt, Joseph. "Organizing to Serve the Disabled." J. of Rehab. November - December 1959.

32. Hunt, Joseph. "President's Program for the Disabled." America. November 27, 1954.

Patterns for dealing with problems of disability differ to extreme in differing societies. The customs in a given society, regardless of how illogical they may seem to outsiders, are part and parcel of that society's total way of life. For example, disabled persons may be especially privileged, invested with mystic or supernatural powers, or abandoned with due tribal ritual to perish. Or--as we strive to do--they may be treated as individuals who (happening to deviate from the usual in some way) are otherwise endowed with the same kinds of human abilities, aspirations, and feelings as the so-called "normal."

In our complex world many kinds of programs and approaches are needed to cope with problems of disability. The diversity of disabilities, abilities and needs of handicapped persons, and the magnitude and complicated structure of our society call for heterogeneous organized programs under a variety of auspices. There is, for example, emphasis on prevention, early discovery, treatment or control of disabling conditions. Some of the other varied approaches include: development of public understanding, including employer acceptance; special education; engineering of jobs and homes (e.g. modified equipment); special privileges (e.g., income tax exemption for the blind); recreation (e.g., clubs, basketball teams); crippled children's services; facilities such as rehabilitation centers and workshops; talking books for the blind; employment services; income-maintenance programs, etc.

The programs may be governmental or voluntary, national, State or local. Some are for designated types of disabilities; some for defined age groups; some for certain types of services. Many are for the disabled only, but some are for other defined groups including disabled persons within the larger group.

A new counselor needs to ascertain what programs are actively operating in his area, acquaint himself fully with them, and develop a comfortable and mutually satisfactory way of working together with personnel of related agencies.

Few, if any, communities have all the resources and programs needed for complete, well-rounded services to meet all the needs of all the disabled persons who live there. The counselor needs to know and work constructively with all programs which touch the lives of disabled persons in his area and to help build broad community programs to meet their varied needs (6, 8).

Principles and methods of maintaining productive working relationships with specific programs operating in the counselor's area include:

Knowing the specific services offered and circumstances in which they are given.

Understanding the philosophy, purpose and basis for limitations of services.

Knowing how services are provided and the individuals who provide them.

Interpreting vocational rehabilitation services, needs and methods.

Explaining the basis for vocational rehabilitation policies and actions.

Jointly developing practical plans for working together, e.g., agreeing on respective responsibilities; referral criteria and procedures; reporting back to referral source; team evaluation and services; sharing information about individuals as appropriate; communicating with appropriate persons before intended visit.

Fulfilling responsibilities promptly and fully.

Joining in specific cooperative projects.

Giving good service to disabled individuals.

Some of the methods for community organization (6, 8) in behalf of a sound and integrated plan to meet the varied kinds of needs include:

Taking active part in community planning for services to individuals and groups.

Supporting establishment of new programs and development of existing programs to meet demonstrated unmet community needs.

Cooperating in community efforts to identify extent and nature of needs related to disability in the area and the kinds of programs needed to meet them.

Interpreting the vocational rehabilitation program to community groups.

Among the major cooperating programs the counselor needs to know and work with are:

Old-Age and Survivors Insurance--a federally administered contributory insurance program for income-maintenance of retired insured workers over 65 and their survivors in certain circumstances. Also includes provisions for cash benefits to insured persons of 50 years or more who become unable to work because of disability; for cash benefits to disabled "children" who are dependents of workers entitled to retirement benefits and whose

disability has existed since before they reached 18 years of age; to protect the benefit rights of individuals who become unable to work because of disability.

(NOTE: The disability provisions are administered by the Bureau of Old-Age and Survivors Insurance through agreements with State agencies--the State vocational rehabilitation agency in most States--which evaluate the disability and make a finding as to whether the individual is entitled to benefits.)

Public Assistance--grant-in-aid programs, administered by State welfare departments which provide financial assistance and welfare services to needy individuals as follows: children who are dependent because of incapacity, death, or absence of a parent (ADC); blind (AB); permanently and totally disabled (APTD); aged (OAA).

States or localities also provide assistance to many needy persons through general assistance or other programs.

Crippled Children's Services--grant-in-aid programs providing medical and related services to crippled children. Administered by State Health Departments in most States.

Public Health--State, county or city health programs for prevention of disease and some personal health services. Some health units provide medical care.

Employment Service--a Federal-State program to serve employers and unemployed individuals. Administered by State employment service agencies. Includes guidance and placement for handicapped persons.

Workmen's Compensation Programs--State programs for the dual purpose of compensating for loss or reduction of earning power of workers disabled in the course of employment; limiting the liability of employers for injury or death of employees. Administered by State commissions with judicial power, or by State courts.

Special Education--provisions for education of exceptional children (gifted or handicapped). Includes special classes or other special provisions in the State or local public school system and State schools for certain groups (e.g., blind, deaf).

Programs for selected disability groups--many voluntary national organizations with State or local affiliates are active in providing or promoting services and/or research for certain disability groups (e.g., National Association for Retarded Children, United Cerebral Palsy Association, The National Foundation, National Tuberculosis Association.)

Various Other Programs--Veterans Administration, Wage and Hour Administration, President's Committee on Employment of the Physically Handicapped, and others.

SUMMARY

Public interest in the care and treatment of the disabled has been aroused. It can only follow that this interest will continue and will in time focus more strongly on newer and better techniques of serving the disabled. Each year brings improvements in rehabilitation facilities and services. All professional personnel and related groups are extending their full support. Rehabilitation is an investment in human welfare based on sound economic as well as humanitarian grounds. It is an effective means for helping the disabled to help themselves, and in so doing extends to the handicapped person an opportunity for economic independence and security.

A most essential consideration in all rehabilitation plans is the full utilization of community resources and close cooperation of the people of the community--on a "team" basis. Using this frame of reference, it will be easier for the rehabilitation process to proceed in an orderly and effective fashion.

References and Suggested Readings

1. Anderson, R. N., The Disabled Man and His Vocational Adjustment. New York: Institute for the Crippled and Disabled, 1932.

2. Clough, G. Sr.,"Teamwork in Rehabilitation." American Arch. Rehab. Therapy, March 1956.

3. Gorthy, W. G., Rehabilitation, A State Responsibility. New York: Institute for the Crippled and Disabled, 1955. (Rehabilitation Service Series Number 10, October 10, 1955.)

4. Graham, E. C. and Mullen, M. M., Rehabilitation Literature, 1950-1955. New York: McGraw Hill, 1956, 621 pp.

5. Harrower, M. (Ed.), Medical and Psychological Teamwork in the Care of the Chronically Ill. Springfield: Thomas, 1955. 232 pp.

6. Porter, Edgar B., "Community Organization - The Dynamics of Community Action." J. of Rehabilitation. July - August 1953.

7. Sallak, V. J.,"A Community Approach to the Rehabilitation of the Handicapped." J. of Educational Sociology, 17, 342-351. Feb. 1944.

8. Smith, J. Hank and Porter, Edgar B., "Community Organization - A Plan of Action." J. of Rehabilitation. September - October 1953.

9. Soden, W. H., (Ed.) Rehabilitation of the Handicapped, A Survey of the Means and Methods. New York: Ronald Press, 1949. 399 pp.

10. Sullivan, O. M.,"Meeting the Needs of the Handicapped Child." Crippled Child. February 1936. 125: 5: 120-124.

11. Team Concept and Techniques in Rehabilitation, Symposium 2nd June Workshop. Institute for Crippled and Disabled; Columbia University, College of Physicians and Surgeons, May 31, June 24, 1955.

12. Whitehouse, F. A., "Teamwork: Clinical Practice in Rehabilitation." Except. Child. 1953, 19, 143-153.

The development within the rehabilitation counselor of sound basic assumptions and an underlying philosophy of rehabilitation controls to a large extent his perceptions of his job, and therefore, his feelings regarding the services he should extend to his clients. The philosophy that the counselor eventually develops will be a product not only of his own thinking, training, and experience, but a reflection of the thinking of his superiors and the general tone set by the agency for which he works. It is important that every counselor continue to evaluate his own attitudes and feelings toward the handicapped and towards the program in which he is engaged in order to grow and develop as a professional worker.

Concepts About the Handicapped

The National Council on Rehabilitation (23) defines rehabilitation as "the process of restoring the handicapped individual to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable." This definition envisions a process aimed at helping handicapped individuals reach the highest capacity for usefulness possible. Vocational rehabilitation services not only those capable of attaining full time, competitive employment in the labor market, but extends services to those persons who are capable of part-time, non-productive, sheltered, home-bound, or self-employment.

The assumption underlying the formation of special programs for the handicapped seem to involve two basic assumptions:

> First, that every member of a democratic society has an inherent right to the opportunity to earn a living, and make his contributions to society.
>
> Second, that society has the obligation to equalize, as best it can by special services, the disabled person's opportunity to earn a living equal to the opportunity possessed by the non-disabled members of society.

These assumptions are particularly important in American society which places great emphasis upon self-sufficiency, hard work, industriousness, contribution to society, and upward social mobility of the individual. To the extent that the handicapped individual is unable to obtain these goals, he suffers a loss of personal dignity, prestige, and self esteem both as a member of society and as a member of a family. Wilcox (25) notes that all of the definitions of adjustment offered by psychologists include the concept of independence and productivity, and that within American society, "The status of independence is generally considered to be a hallmark of the attainment of adulthood." Herein lies the dilemma of the handicapped person, for only insofar as he can demonstrate his physical or mental incapacity is his dependency accepted. The problem of achieving independence is difficult for all persons, but

increasingly so for the physically and mentally handicapped individual. In addition to this there are several other variables which complicate the handicapped individual's attempts to reach a solution to the dependency - independency problem. First, the enforced idleness into which the disabled person is forced often has a large overlay of secondary gains, resulting in the intensification of dependency seeking behavior and a general flattening out of affect. Second, the disabled per se may come to constitute an unconsciously sought-for goal of dependency.

Concepts About the Community

The problems of disability, chronic disease and aging have a significant relationship to community welfare. Some basic understanding of these relationships is important to the rehabilitation counselor, for the community maintaining a large number of disabled and idle workers faces a growing economic and social problem. The process of involving the community in rehabilitation of the disabled will not be successful solely as a humanitarian venture, but only as it can demonstrate that vocational rehabilitation programs are "good business" for the community. In many cases this is quite easy to show, since unproductiveness results in a loss of wealth and income for the individual and makes it necessary for the community to help support him and his family. The public gets the ultimate effect of the individual disability in the form of a decrease in tax payment, reduced purchasing power and generally lowered social tone. It also results in increased taxation for the individual members of society (16).

As mentioned previously, evidence would tend to indicate that many employers have an aversion to employing the disabled, as they believe them less effective and more accident prone. Many have either a conscious or unconscious abhorrence of physical disability, and fear a rise in insurance rates and a disturbance in their pension systems if they hire the disabled. In some States the lack of a "second injury" clause in workmen's compensation places the burden of second and previous injuries on the employer.

The concept of employability, as far as the physically and mentally handicapped are concerned, is that the person must be employable and be given the opportunity to work. The factors in employability include his physical or mental ability to do a specific job; mental and educational ability to hold a job once he is given the opportunity to do it; adequate personality to perform on the job, skill in a job, and, last but not least, opportunity to work. The methods by which opportunity to work may be made available to the handicapped are threefold. He can work for others; he can engage in sheltered workshop or home employment; he can be established in his own business.

The concept of automation has direct bearing upon the question of employability. Friedman (7) states that under present industrial conditions technical progress means unemployment. Under employment means greater selectivity on the part of the employer who is not guided by humanitarian motives, but by a desire to realize higher profit. Hence, with higher automation may conceivably come more difficulty in placing the physically handicapped. In many cases, it would appear that the single

monotonous function of the average unskilled worker will gradually disappear and the workers without skills will either disappear or become a drudge on the employment market. However, job satisfaction is likely to increase under conditions of automation. Mann and Hoffman (12) report significantly higher morale for men in a factory characterized by automatic control than in an older plant. However, another finding was that higher tension characterized workers in the automatic control factory . It would seem that many of the jobs involving automatic machines could be readily performed by disabled workers.

Concepts about Rehabilitation

In discussing the rehabilitation process we need to make a distinction between disability and handicap. A disability is defined (9) as "a condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. It is essentially a medical thing." A handicap is defined (9) as "the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level. The handicap is the measure of the loss of the individual's capacity, wherever evident. It is an individual thing composed of the barriers which the handicapped person must surmount in order to attain the fullest physical, mental, social, vocational and economic usefulness of which he is capable." The rehabilitation process is concerned primarily with the handicapping problems resulting from disability, rather than with the disability per se. Furthermore, it deals with those problems for which the individual lacks the necessary resources.

The determination of eligibility for vocational rehabilitation is based upon considerations of the total interplay of factors surrounding an individual's handicap. (For definition and criteria see - The Vocational Rehabilitation Diagnosis.)

The services that are necessary to render a person employable are based upon the individual needs of a given client. The nature and extent of the services as directly provided by a State vocational rehabilitation agency are defined in the Vocational Rehabilitation Act (See History and Legal Basis of the Vocational Rehabilitation Program.) Services that are a necessary part of the overall rehabilitation plan, but which the agency is unable to participate in financially, (e.g. family maintenance while client is undergoing rehabilitation) may be secured from cooperating agencies.

The job of serving the handicapped population is one of human engineering, i.e., to find the disabled individual, ascertain his needs and provide the necessary services. The means of determining needs of any given client is through the individual case study method. It will generally be the responsibility of the rehabilitation counselor to integrate the activities of a number of people, bringing to bear the skills of a number of professions needed in total rehabilitation planning. Clearly all services are not contained within the rehabilitation agency. The agency contributes directly in: determination of eligibility;

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determination of services needed; counseling, placement and follow-up sources; making arrangements with other agencies for other necessary services; and supervising the rendition of services.

Other necessary services are provided by purchase from, or arrangement with, other agencies, institutions or individuals.

Concepts about the Rehabilitation Counselor's Job

The counselor's role in the rehabilitation process is basic to the success or failure of any given program. The agency is personified in the counselor, and through him the client gains his perception of vocational rehabilitation. The rehabilitation counselor establishes a professional relationship with the client, continuing from the onset or recognition of disability to the attainment of his greatest competitive capacity. The counseling relationship is a dynamic, ongoing process in which the personalities of the counselor and client interact in such a way as to maximize present vocational assets and foster realistic self acceptance in the client.

A rehabilitation diagnosis is made by the counselor which takes into account all of the assets and limitations of the handicapped individual in every pertinent aspect of his experience - physical, social, psychological, economic and vocational. The diagnosis incorporates into its structure a discriminating use of all community services and resources. These are individualized to make their most effective contribution to the unique needs of the particular client.

Necessary Skills

The rehabilitation counselor's job is not one which can be performed effectively by someone who merely "likes people." There are basic training requirements that necessitate a high level of intellectual ability, the development of insights and sensitivities that can best be gained through formally supervised training in counseling. These include the following:

> The ability to establish and maintain a wholesome counseling relationship, including an understanding of the importance of the client's views and duties throughout his rehabilitation and an ability to relate the counselor's own and other professional skills to the client as a person. The counselor must demonstrate an understanding and acceptance of human behavior, not just in the abstract but as it is encountered in a particular client. The broad pervasive effects of the environment in shaping human motivation should be realized.
>
> The evaluation of personality dynamics, skills, aptitudes, interests and capacities in the on-going behavior of the client is to be performed in a professional and scientific manner. "Hunches" or "conjectures" are not enough, but

must be substantiated through careful appraisal of all factors involved and their inter-data consistency. Specialized knowledge of physical and psychological handicaps as gained through graduate level training is necessary.

Awareness of community organization is needed. The job structure of the community, job requirements, trends, opportunities, preparation, and training facilities would be included. There is need for familiarity with employment procedures in all fields and ability to relate them to the needs of both client and industry. There is need for the development and utilization of community resources that can assist in the total rehabilitation of the client.

Performance of an effective public relations function which will create an improved community understanding of total rehabilitation and its relationship to education, health, and welfare services.

Necessary Knowledge

The counselor needs to possess a basic understanding and professional knowledge of human behavior as related to personal, social and vocational adjustment, including ability to evaluate aptitudes, skills, interest and educational background. It is necessary to apply this basic knowledge of the relationships of such factors to training and to occupational requirements. The counselor needs to have basic knowledge of the possible effects of handicaps on personality in relation to emotional and vocational adjustment.

Federal, State and local laws are pertinent to the rehabilitation of disabled persons. Working knowledge of these laws is essential to the efficient operation in vocational rehabilitation. The current status of social legislation, of services and policies of social welfare programs and of current social and economic problems are relevant to the rehabilitation counselor's job.

The counselor should gain an understanding of the policies of employers in his community in relation to individuals with physical and mental handicaps.

Necessary Duties

It is the responsibility of the rehabilitation counselor to obtain, analyze and evaluate pertinent information about a handicapped client. Medical diagnosis is arranged for, to determine the kind and extent of disability and rehabilitation possibilities. Eligibility is then determined by the counselor on the basis of a clear understanding of the handicapping effects of a disability, within the framework of agency policy.

Basic information is secured about the applicant's educational background and work experience, special interests, social and economic circumstances, personality traits and attitudes. The counselor provides for the administration and interpretation of psychological tests and integrates the information they provide into the formulation of a sound rehabilitation plan.

The counselor assumes a primary responsibility to the client. This responsibility implicitly affirms that the counselor's role will provide for positive personality development in the client, continuing from initial interview until final disposition. The client is helped throughout the rehabilitation process to learn new techniques that will assist him in meeting problems of personal, social and vocational adjustment. Tangible services, i.e., medical, health, physical restoration, pre-vocational and vocational training, transportation, and maintenance are made available to the client when needed.

In the final phase, job seeking, the counselor helps the client secure employment that is consistent with his personality, capacities, and preparation. After the client has a job, it becomes the counselor's responsibility to help him meet the problems of adjustment to the work-a-day world. Follow-up visits are made, as necessary for the vocational adjustment of the individual.

For the purpose of his own enlightenment, case conferences, and legal requirements, the counselor prepares and maintains necessary vocational rehabilitation records and makes reports as required. Adequate case reports are kept summarizing the pertinent factors surrounding a client to enable the counselor to make inferences, set up hypotheses to be checked, and form a sound basis for making a rehabilitation diagnosis. Records are also maintained as a means of evaluating the rehabilitation program through meaningful research.

References and Suggested Readings

1. Baker, H. J., The Art of Understanding. Boston: The Christopher Publishing House, 1940. 400 pp.

2. Board of Education, Chicago, Illinois. The Needs of Physically Handicapped Children.

3. Colby, Martha Guernsey, "The Early Development of Social Attitudes Toward Exceptional Children." J. of Genetic Psychology. March 1944. 64: 105-110.

4. Coughlin, Ellen Whelan, "Some Parental Attitudes Toward Handicapped Children." Child. August 1941. 6:2: 41-45.

5. Davies, S. P., The Mentally Retarded in Society. New York: Columbia University Press. 1959. 248.

6. Fenton, J. and Conner, Frances P., "The Changing Picture in the Education of Children with Crippling Conditions and Special Health Problems." Exceptional Child. 1949, 25, pp. 256-262, 277-278.

7. Friedman, G., Industrial Society: The Emergency of the Human Problems of Automation. Glencoe, Illinois: The Free Press, 1955.

8. Gellman, W., "Roots of Prejudice Against the Handicapped." J. of Rehabilitation. Vol. 25, No. 1. January - February 1959, 4.

9. Hamilton, K. W., Counseling the Handicapped in the Rehabilitation Process. New York. Ronald Press, 1950.

10. Lavos, G., "Personality and a Physical Defect." J. of Exceptional Children. January 1941. 7: 4: 124-128, 145-146.

11. McAuliffe, T. P., "Prejudices Against the Handicapped." Crippled Child. February 1935. 12: 5: 116-119, 138.

12. Mann, F. C. and Hoffman, R. L., "Individual and Organizational Correlates of Automation." J. of Social Issues, 1956, 12 (2), 7-23.

13. Mussen, P. H., "Attitudes Toward Cripples." J. of Abnormal and Social Psychology. July 1944. 39: 3: 351-355.

14. Neuschutz, Louise M., Vocational Rehabilitation for the Physically Handicapped. Springfield, Illinois: Thomas, 1949, 136 pp.

15. Pinter, R., Eisenson, J., and Stanton, M., The Psychology of the Physically Handicapped. New York: Crofts, 1941.

16. Porter, Edgar B., "What is Rehabilitation?" J. of Rehabilitation. July - August 1950.

17. Rusk, H. A., "...But the Spirit Giveth Life." Survey. April 1949. 85: 4: 212-215, 238.

18. Sallak, V. J., "A Community Approach to the Rehabilitation of the Handicapped." J. of Educational Sociology. 17, 342-351, February 1944.

19. Scientific American. (Editors), "Automatic Control." New York: Simon and Schuster, 1955.

20. Stein, Elizabeth, "The Behavior of the Handicapped." American J. of Mental Deficiency. April 1949. 53: 4: 649-652.

21. Sullivan, O. M., "Meeting the Needs of the Handicapped Child." Crippled Child. February 1936. 125: 5: 120-124.

22. Tenny, J. W., "The Minority Status of the Handicapped." Except. Child. 1953, 19, 260-264.

23. Whitehouse, F. A., "Teamwork, Philosophy and Principles." American Assn. of Medical Social Workers. Pittsburgh, Pa. June 21, 1955.

24. Whitehouse, F. A., "Utilization of Human Resources. Philosophic Approach to Rehabilitation." Dis. Chest. 1956, 30 (6), 606-627.

25. Wilcox, R. K., Passive-Dependency in Rehabilitation. Unpublished doctoral dissertation, University of Missouri, 1958.

26. Wood, V., "Casework Practice in Mental Health Clinics." J. Psychiatric Social Work. 1953, 22, 64-66.

HISTORY AND LEGAL BASIS OF THE VOCATIONAL REHABILITATION PROGRAM

The early history of the vocational rehabilitation movement in America was characterized by the work or private agencies such as the Red Cross Institute for Crippled and Disabled, the Cleveland Rehabilitation Center, the Curative Workshop of Milwaukee, etc. Nevertheless, the first real interest on a national level was stimulated in 1918 when Congress passed the Smith-Sears Act for the vocational rehabilitation of veterans. Massachusetts in 1918, became the first State to enact rehabilitation laws for disabled civilians. By 1920 eight States had initiated rehabilitation programs; in 1921 twenty-five states had entered the program; by 1924 three more States were added; by 1930 eight more; by 1940 seven more. However, more than thirty-five years elapsed before all the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands and Guam were engaged in rehabilitation work.

Chronology of Legislation

1. The Vocational Rehabilitation Act of 1920 was inaugurated under a special act of Congress to provide a program of rehabilitation for disabled civilians. It was stimulated by the success of the vocational rehabilitation legislation for veterans of World War I. The primary purpose of the act was to encourage States to undertake similar legislation and provide similar services for disabled civilians. The appropriations under this act were on a temporary basis and provided the following services:

   a. Allocation of funds to the States were to be made according to population with expenditures authorized on a 50-50 matching basis.

   b. The funds were to be used to provide vocational guidance, training, occupational adjustment, prosthesis and placement services only.

   c. The Act provided a maximum Federal authorization per State.

   d. The authority for granting funds was enacted on a temporary and not a permanent basis. This basic Act continued from 1920 to 1924 when it was extended by Congress for six additional years.

2. In 1930 the Federal Act was again extended by Congress for three years. The Couzen's Amendment to this Act provided for grants to States prepared to match them, and funds were withheld from States who were not in a position to match their population allotments as far as funds were concerned on a 50-50 basis. In 1932 further extension of four years was granted by Congress.

3. In 1935 the Vocational Rehabilitation Program was enacted on a permanent basis through the Federal Social Security Act.

4. In 1936, the Randolph Shepard Act initiated the vending stand program for the blind in Federal and other buildings.

5. In 1939 Amendments to the Social Security Act again increased authorization and appropriations.

6. The two major laws which have provided the greatest impetus to the vocational rehabilitation program, Public Law 113, The Vocational Rehabilitation Amendments Act of 1943, and Public Law 565, The Vocational Rehabilitation Amendments Act of 1954 will be discussed later in more detail.

During the period from 1920 to 1933 the Vocational Rehabilitation Act was administered by the Federal Board for Vocational Education, and from the period from 1933 to 1943 by the Office of Education. During the period from 1933 to 1939 the Office of Education was a constituent unit of the Department of Interior and was transferred to the Federal Security Agency in 1939. The Federal Board for Vocational Education remained an advisory body to the Office of Education from 1933 to 1938 when it was abolished. The Department of Health, Education, and Welfare, where the program is currently administered was established on a Cabinet level in 1953.

<u>The Vocational Rehabilitation Act, Amendments of 1943</u>
<u>Public Law 113, 78th Congress</u>

This Act gave great emphasis to the Vocational Rehabilitation movement, and contained the following provisions.

1. The fiscal provisions of the rehabilitation law were liberalized. Fixed ceilings on grants-in-aid to States were removed.

2. There was Federal reimbursement to the States for all administrative costs, and 100% reimbursement for the expenses incurred in offering vocational guidance and placement services to the handicapped.

3. The basic concept of the program was changed from that of a scholarship to a "needs of the client" basis.

4. Services were extended for the first time to the mentally disabled and other services were expanded. These included such new additions as the cost of medical and psychiatric examinations, medical and surgical treatment, hospitalization, training, training supplies, maintenance during rehabilitation, necessary travel, occupational tools, equipment and licenses. All of these expenses were to be shared with the States on a 50-50 basis.

5. The cost of the total rehabilitation of war disabled veterans was still to be paid entirely from Federal funds.

6. The Act also contained special provisions for services to the blind.

The Vocational Rehabilitation Act, Amendments of 1954
Public Law 565, 83rd Congress

The Vocational Rehabilitation Act of 1954 was designed to provide a stronger financial structure and to improve the administration of the program. It encourages expansion of rehabilitation facilities and workshops, authorizes the financing of research studies and demonstration projects to provide new methods and techniques to improve the quality of rehabilitation services. It authorizes training programs to increase the numbers of professionally qualified people to work with the disabled, and makes it possible for the States to bring together rehabilitation services to more disabled people and to the more severely handicapped. It also opens the way for non-profit voluntary organizations to participate directly in the nationwide public vocational rehabilitation program. Speaking of the Act, which he signed on August 3, 1954, President Eisenhower has the following to say:

> "In the first place, it reemphasizes to all the world the great value which we in America place upon the dignity and worth of each individual human being. Second, it is a humanitarian investment of great importance, yet it saves substantial sums of money for both Federal and State governments."

The Act which was designed to improve and expand the nation's resources for restoring physically handicapped individuals to active work was passed unanimously by both Houses of Congress. It represents the first major legislative change in the State-Federal Vocational Rehabilitation Program in more than ten years and a major break through as far as new programs are concerned.

New Grant System Under Public Law 565

The Act provides for a three part grant structure consisting of grants for: (1) the support of basic vocational rehabilitation services, (2) extension and improvement of rehabilitation services and (3) special projects. Each of these three parts of the grant will be discussed in detail.

1. Support Grants: "Support grant funds are allotted to the States on the basis of population weighed by per capita income with provision for a floor, or base allotment. In order to earn the base allotment through 1959, State funds must equal 1954 State funds. The excess of the support allotment over the base allotment is earned under matching provisions which provide for

a 60% pivot Federal share and maximum and minimum Federal shares of 70% and 50%. In 1960, 1961, and 1962 the matching on the base allotment is adjusted gradually so that by 1963 the entire support allotment is earned on the basis of a 60% pivot share and maximum and minimum Federal shares of 70% and 50%."

2. Extension and Improvement Grants are allotted to the States on the basis of population, with provision for a minimum allotment of $5,000 or such other sum as the Congress may specify in making appropriations. This type of grant provides funds for extending and improving rehabilitation services which have been provided for in the State plan. A Federal share of not more than 75% is authorized for each project, limited to three years for any one project.

3. Special Project Grants include grants to States and public or other non-profit organizations and agencies for paying part of the cost of projects for research, demonstrations, training and traineeships (separately described below), and projects for the establishment of special facilities and services which hold promise of making a substantial contribution to the solution of problems in vocational rehabilitation. Applications for special project grants for research and demonstrations may be made to the Director of the Office of Vocational Rehabilitation, who reviews them with the assistance of the National Advisory Council on Vocational Rehabilitation. This Council was established in accordance with the new law on January 31, 1955. Any grant which will be used for direct services to physically handicapped individuals or for establishing facilities which will render direct services to such individuals must have the prior approval of the appropriate State vocational rehabilitation agency in the State in which the grant applicant is located.

Expansion of Facilities

The new law authorizes Federal participation in expanding, remodeling or altering existing buildings to render them suitable for use as public or non-profit workshops or as rehabilitation facilities for the severely disabled. Federal funds, when matched with State funds, may also be used to help provide initial equipment and--in the case of rehabilitation facilities--to provide the staff during the first year of operation. This feature of the law supplements the provisions for construction of comprehensive rehabilitation facilities under the Medical Facilities Survey and Construction Act of 1954. For purposes of this law, the term "workshop" is defined as a place where any manufacture or handiwork is carried on and which is operated for the primary purpose of providing remunerative employment to severely handicapped individuals who cannot be readily absorbed in the competitive labor market.

Federal grants may be made under the vocational rehabilitation law to establish or expand rehabilitation facilities organized for the "primary purpose of assisting in the rehabilitation of physically handicapped individuals." Two types of facilities may be aided:

1. A facility which provides one or more of the following types of services: (a) testing, fitting, or training in the use of prosthetic devices; (b) pre-vocational or conditioning therapy; (c) physical or occupational therapy; (d) adjustment training; or (4) evaluation or control of special disabilities.

2. A facility which provides an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision. The major portion of such evaluation and services must be furnished within the facility, and all medical and related health services must be prescribed by, or be under the formal supervision of, persons licensed to practice medicine or surgery in the State.

Training Personnel

The shortage of trained personnel to work with the disabled constitutes one of the most serious problems in rehabilitation. To meet this problem, the new law authorizes Federal participation in the training of professional personnel in the various disciplines demanded in this field. Federal funds may be used for the following:

1. Teaching Grants: These are made to universities and other educational institutions to establish, expand, or improve professional training in fields related to vocational rehabilitation in which serious national shortages exist. These fields include rehabilitation counseling, social work, psychology, work with the blind, speech and hearing therapy, physical therapy, occupational therapy, rehabilitation aspects of nursing, and certain courses for physicians in the field of rehabilitation. Such grants are made to enable educational institutions to employ additional instructors or clinical training supervisors and to meet related instructional expenses.

2. Traineeships: Grants are made for scholarships and stipends to enable selected students to secure professional training in the vocational rehabilitation fields in which the greatest shortages of personnel and support exist. Grants also are made for advances or postgraduate training of personnel to produce leaders and teachers of rehabilitation in the various professional fields, and for research fellowships.

3. Institutes for Short-term Training Courses: Grants are made to educational institutions or to their affiliated rehabilitation facilities to provide short-term training in rehabilitation methods and specialized training intended to increase skill in teamwork among professional personnel.

State and Local Administration

The new law is designed to give the States maximum authority and responsibility in carrying out their programs of vocational rehabilitation. The law relaxes previous requirements that responsibility for administering the program must be borne by State boards for vocational education. The States may, at their own option, either continue their rehabilitation programs under their boards for vocational education, or place them under separate agencies concerned primarily with rehabilitation.

In each State having a separate agency serving the blind, this agency may function as the sole State agency responsible for administering that part of the State plan relating to rehabilitation of the blind.

Further flexibility is provided by authorizing the States to decentralize administration of their rehabilitation programs to county, municipal, or other governmental agencies. When such decentralization is effected, however, supervision must be exercised by the State agency for vocational rehabilitation.

Cooperation With Other Agencies

Strong cooperative relationships are required between State agencies for vocational rehabilitation and all other agencies--such as public employment services--which provide services needed in the vocational rehabilitation and job placement processes. Within the Federal Government, coordinated planning is a requirement of the law. The Secretary of Labor and the Secretary of Health, Education and Welfare are directed to develop and recommend to appropriate State agencies policies and procedures to promote the employment of disabled men and women who have received services under the rehabilitation program. In addition, the Secretaries of these two Departments are directed to work with the Chairman of the President's Committee on Employment of the Physically Handicapped in developing methods to secure the maximum use of services of the Committee and its cooperating State and local organizations in promoting employment opportunities for the disabled.

Federal Administration

The new law emphasizes and specifies the responsibilities of the Department of Health, Education and Welfare for the exercise of leadership in the rehabilitation program. The Department is required to make studies, investigations, demonstrations, and reports on various aspects of the needs and abilities of handicapped people; to conduct demonstrations of new rehabilitation techniques and methods; to provide technical assistance to the States; to disseminate public information regarding the program; and otherwise to promote the cause of rehabilitation and employment of disabled people.

District of Columbia Rehabilitation Service Transferred

Public Law 565 provided for the transfer of the District of Columbia Rehabilitation Service from the U. S. Department of Health, Education and Welfare to the Government of the District of Columbia. This transfer was effected November 1, 1954.

Randolph-Sheppard Act Amended

The new legislation strengthens the program of licensing blind persons to operate vending stands initiated under the Randolph-Sheppard Act of 1936, by extending the provisions of that Act to include Federal property as well as Federal buildings. The amendments require heads of Federal agencies in control of Federal property to prescribe regulations designed to assure such preference after consultation with the Secretary of Health, Education and Welfare and with the approval of the President. The assignment of income from vending machines also must be made in a manner to achieve and protect this preference.

"Shut-In" Survey

The new rehabilitation law directs the Secretary of Health, Education and Welfare to make a thorough study of existing programs for teaching and training handicapped persons whose disabilities confine them to their homes, and to determine whether additional services or programs are necessary, particularly in rural areas.

Related Legislation

In addition to the Vocational Rehabilitation Act (Public Law 565, 83rd Congress) there is related Federal legislation which contributes materially to a strong program for rehabilitation of the disabled. In 1949 the Federal Employees Compensation Act was amended to make vocational rehabilitation an integral part of the Federal Government's benefits program for its employees injured in line of duty. Under these amendments, a permanently disabled individual, whose disability is compensable under the Act, may be required to undergo vocational rehabilitation with the cost of these services being a charge against the Employees Compensation Fund. It is further provided that the Administrator shall, insofar as practicable, utilize the services or facilities of State agencies administering the Vocational Rehabilitation Act in this regard. As an added incentive, any disabled individual undergoing vocational rehabilitation may receive additional compensation necessary for his maintenance not to exceed $50 per month. In the event the individual refuses without good cause to undergo a program of rehabilitation, his benefit payments may be reduced.

In 1954 the Medical Facilities Survey and Construction Act was amended to authorize Federal financial participation in the building of new rehabilitation facilities. The increase in these facilities, which

the Act makes possible, is making physical restoration services available to many more severely disabled individuals. The Act also continues Federal aid for construction of hospitals and initially authorizes such aids for the construction of chronic disease hospitals, nursing homes, and diagnostic and treatment centers, all of which have a bearing on the program of vocational rehabilitation.

The 1954 Amendments to the Social Security Act provide for the preservation of benefit rights under Old-Age and Survivors Insurance for workers and their dependents during period of extended disability. The disability provisions of the Act were amended further in 1956 and 1960 to provide for cash payments to disabled workers and their dependents, and to disabled "children", whose parents are or were OASI beneficiaries and whose disability began before they reached age 18. These amendments also provide for the automatic referral of all applicants for such benefits to the State vocational rehabilitation agencies for rehabilitation services. Like the Employees Compensation Act, these amendments also provide that any recipient of cash benefits who, without good cause, refuses to accept rehabilitation services may have his benefits reduced. On the constructive side, as an incentive to rehabilitation, provision is made that the earnings a beneficiary may have pursuant to a program for his rehabilitation may be disregarded as earnings for a period of 12 months, hence have no effect upon his disability payments during this period. In most States the vocational rehabilitation agencies make the determinations of disability for the Social Security Commissioner. Information and data collected in the disability determination process is utilized by the State vocational rehabilitation agencies in making rehabilitation assessments and in providing rehabilitation services.

Since Old-Age and Survivors coverage is almost universal, the number of referrals of disabled individuals for rehabilitation services from this source is potentially very large. It is estimated that about 5,000 applications will be made yearly for "child" benefits, and 250,000 applications for "worker" freeze and cash payment benefits when present backlogs are disposed of and the program levels off to its normal operating load. The impact of this program on the vocational rehabilitation program is very great, since all of these applicants may require an assessment of their work potential.

The 1956 Amendments to the Social Security Act relating to public assistance provide, among other things, for Federal financial participation in State public assistance expenditures for (a) medical care for recipients, and (b) welfare services to help assist recipients toward self-support and self-care. Working arrangements between public assistance and vocational rehabilitation agencies are directly involved in State public assistance plans which provide for services to help applicants or recipients obtain self-support. State public assistance plans were required to describe by July 1, 1957, the services, if any, in aid to dependent children, aid to the blind and aid to the permanently and totally disabled, "...including a description of the steps taken to assure, in the provision of such services, maximum

utilization of other agencies, providing similar or related services." The medical care amendments also have direct implication for services offered by the two programs, and enhance possibilities for cooperative work between the State vocational rehabilitation agencies and the State welfare agencies.

SUMMARY

During the period from 1920 to 1943 the vocational rehabilitation program operated with limited Federal support. With the passage of Public Law 113 and Public Law 565 the future of the program has been assured. The concept of a program with its appeal to both the liberal and the conservative members of both houses has been reflected in the final unanimous vote for the passage of Public Law 565. It is now up to rehabilitation personnel to shoulder the burden of making the transfer from legislative provisions to actual case service to the handicapped.

References and Suggested Readings

1. Administration of Civilian Vocational Rehabilitation, A Statement of Policies: U. S. Government Printing Office, December 1926.

2. Annual Report of the Department of Health, Education, and Welfare. 1958.

3. New Hope for the Disabled, U. S. Government Printing Office, Washington, D. C.

4. Public Law 113 of the Seventy-Eighth Congress, cited as the "Vocational Rehabilitation Act."

5. Public Law 236 of the Sixty-Sixth Congress, cited as the "National Civilian Vocational Rehabilitation Act."

6. Public Law 482 of the Eighty-Third Congress, cited as "Medical Facilities Survey and Construction Act of 1954."

7. Public Law 565 of the Eighty-Third Congress, cited as the "Vocational Rehabilitation Act Amendments of 1954."

8. Public Law 732 of the Seventy-Fourth Congress, amended in 1954.

9. Public Law 880 of the Eighty-Fourth Congress, cited as "Social Security Amendments of 1956."

10. Statistical information about the State-Federal program of rehabilitation may be found in the Annual Reports of the Department of Health, Education, and Welfare and the Federal Security Agency which preceded it.

COUNSELOR'S PLACE AND FUNCTION IN THE VOCATIONAL REHABILITATION PROGRAM

Since the vocational rehabilitation of a single individual often involves a lengthy process which brings together professional workers from a number of related disciplines, all of whom are engaged in similar and often overlapping work, some difficulties and misunderstanding have occasionally arisen due to semantic problems and traditional professional differences as to how a particular problem could best be solved.

Vocational rehabilitation counseling represents an emerging profession while several older and more established groups, particularly social workers, feel that they have been engaged in vocational rehabilitation work for a number of years. This feeling is expressed in an article by Arthur Dunning (10), entitled "Rehabilitation a New Specialty?" In this article Mr. Dunning raises questions as to the exact role of social work under the rehabilitation process, and questions how the work of the rehabilitation counselor differs from the final aims and objectives of the social worker as a rehabilitation specialist.

The problem is stated more explicitly by Eleanor Cockerell in Dunning's book (10), who says "in the broad meaning of this term (rehabilitation) is contained the essence of what social casework has been endeavoring to offer individuals throughout its long period in growth and development." These same feelings can be found in the writings of other related professional groups such as psychologists, nurses, occupational therapists, professional therapists, and many of the related paramedical fields.

In this part of the manual and in the sections that follow many terms will be used which have previously been identified as part of the vocabulary or technical "jargon" of these other professional groups. It may help to clarify the situation to introduce this area with an explanatory statement to the effect that the vocational rehabilitation counselor's main job is to provide for the vocational rehabilitation of the clients he is seeing. The main technique which he will use is counseling. However, as part of the total process of vocational rehabilitation he may, and generally does, provide services which involve casework, placement, medical referral, and arranges for services to be provided by many related disciplines. All of these services are integrated by the rehabilitation counselor and each represents a part of the total vocational rehabilitation process.

Vocational Rehabilitation Counseling Defined

Vocational rehabilitation counseling may be defined as a process in which the counselor thinks and works in a face to face relationship with a disabled person in order to help him understand both his problems and his potentialities, and to carry through a program of adjustment and self-improvement to the end that he will make the best obtainable vocational, personal and social adjustment.

Vocational Rehabilitation Services Defined

Vocational rehabilitation services are defined as any goods and services necessary to render a handicapped individual fit to engage in a remunerative occupation including: diagnostic and related services required for the determination of eligibility for services and of the nature and scope of the services to be provided (including transportation); guidance; physical restoration services; training; books and training supplies; maintenance; placement services; tools, equipment, initial stocks and supplies, including initial stocks and supplies for vending stands; acquisition of vending stands or other equipment and initial stocks and supplies for small business enterprises conducted by severely handicapped individuals under the supervision of the State agency; transportation; occupational licenses; establishment of workshops for severely handicapped individuals; establishment of rehabilitation facilities; and other goods and services.

The Vocational Rehabilitation Counselor

With the above definitions of rehabilitation counseling and rehabilitation services in mind we can discuss the role of rehabilitation counselor. Most authorities (32) agree that "the core of the rehabilitation counselor's work is counseling." However, no one will deny that he is also continually involved in the process of providing additional service to the rehabilitation client. Nevertheless, he accomplishes this function by establishing and maintaining a counseling relationship which pervades the entire vocational rehabilitation counseling process.

From the location and selection of cases to the completion of services the counselor interprets rehabilitation functions and services to community organizations, agencies and individuals, and coordinates all of these services with the client himself. Responsibility for the evaluation of the client and planning with the individual from the initial counseling interview and diagnostic services to the establishment of eligibility, to planning and arranging for supervision of services, to final job adjustment, are all major functions of the counselor. Also included in his job is the responsibility for effective management of his caseload, case records, correspondence, reports and work flow.

In some individual cases such a large percentage of his time may be given to the integration of services that Patterson (25) in an article entitled "Counselor or Coordinator?" raises some major issues as to the exact functions of the counselor's role. This article will be discussed in the Section on The Rehabilitation Counselor as a Professional Person.

Generally speaking, an essential characteristic which differentiates the work of the vocational rehabilitation counselor from that of other counseling specialists is the fact that the rehabilitation counselor's -

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final aim is to bring about the vocational rehabilitation of the handicapped individual. Lloyd H. Lofquist (21) offers an operational definition of rehabilitation counseling which makes this point quite explicit. He defines rehabilitation counseling as follows:

> "Vocational counseling is a continuous learning process involving interaction in a non-authoritarian fashion, between two individuals whose problem solving efforts are oriented towards vocational planning. The professional vocational counselor and the counselee with a problem are concerned not only with the solution of the immediate problem, but also with planning new techniques for meeting future problems. While the counselee has need for anxiety reduction concerning his vocational problem or set of problems, psychopathology is not involved and the counselee is capable of learning new attitudes and appraising vocational realities with reference to his unique assets and liabilities, without first requiring a major restructuring of his personality. Psychotherapy may result in some measure; but vocational planning, not psychotherapy, is the primary orientation of the process. The vocational counselor serves in this learning process as the reinforcing agency, facilitator of counselee activity, resource person, and expert on techniques for discovering additional data relevant to the vocational planning. A counselor also learns continuously in the process, but keeps his need-satisfaction demands at a level subserviant to those of the counselee."

This definition clearly indicates that while the work of the rehabilitation counselor may involve many different types of problems he is primarily concerned with the total implications of the vocational rehabilitation problem. These, of course, may include vocational problems, health and physical problems, and personal and social problems. Included in these problem areas are the following:

> Vocational Problems - The client may have no understanding of his capacities and interests; the client may need occupational information; or need help in selecting a job objective in line with both his abilities and interests; or need help in selecting and making arrangements for a course of training; he may have financial problems in connection with carrying out a training program; or need help in finding and adjusting to a job.
>
> Health and Physical Problems - The client may not understand the purpose and value of medical examinations or the medical treatment or surgery; he may need to know how treatment may affect his own future potentials for employment and the consequent effects for his family; or to understand the significance of his health or physical limitations in choosing and preparing for a job; he may need financial

assistance to secure physical restoration services; he may need information and guidance in making use of resources for learning to use a prosthetic device, in carrying through a medically prescribed program.

Personal and Social Problems - The client may need to develop motivation for employment and self-support; his personality traits may adversely effect his employment adjustment; he may be unwilling to persevere in the training program; or may not accept the limitations of his disability, or go through with the recommended treatment; he may have emotional disorders or maladjustments that affect practically all aspects of his rehabilitation plan and his ultimate adjustment; and these problems may exist not only independently but in conjunction with various kinds of vocational or health problems.

Four basic counseling concepts should guide the vocational rehabilitation counselor in every case that he works with. These are:

The counselor should establish a good working relationship with his client that is based upon mutual understanding and respect.

The client should achieve an understanding of the functions of the agency, the basis of his eligibility and the basic conditions under which the agency can provide the services he requests or needs.

Through counseling, the counselor and the eligible client should agree upon the most suitable job objective or occupational field for the client, and the services to be provided or activities to be undertaken in order to reach that objective.

In order to reach the above relationship and understanding the counselor should contribute to the objective in either one or both of the following ways: the counselor helps the client, through interviewing and counseling in using medical, psychological, social and vocational data to form a realistic appraisal of his present capacities, his personal characteristics, and job potentialities; to obtain information on job requirements and opportunities; and on the basis of such information and understanding to select the job objective and to carry through a vocational plan that will lead to a job that is best suited to his personal qualifications. The counselor works jointly with the client in a counseling relationship to help him, through physical restorative services, to increase his physical capacities for employment; or through training to increase his vocational skills; or through providing tools, equipment, or other auxiliary

services to facilitate his adjustment to a suitable job.

Although all of the above listed services will not be needed in every case, the most important function of the counselor is to help the client acquire insight into his own capacities, attitudes, interests, and personal characteristics; to relate these to the requirements and possibilities of the occupational world, and to assist him to plan and carry through a program of services which will lead to a successful job adjustment. This level of understanding should be attained by every client to the degree that he is capable of doing so. Many clients do not have such initial insight, and the development of these insights through counseling for self understanding and motivation is the unique achievement of the effective rehabilitation counselor. In some cases, the counselor by means of counseling techniques assists the client to modify basic attitudes that have resulted in social maladjustment, however, as pointed out by Lofquist (21), this is not the essential duty of the rehabilitation counselor and he should be careful not to engage in counseling activities which are beyond his training and competencies.

The Rehabilitation Process

The rehabilitation process is a planned orderly sequence of services related to the total needs of the handicapped individual. It is a process built around the problems of a handicapped individual and the attempts of the vocational rehabilitation counselor to help solve these problems and thus to bring about the vocational adjustment of the handicapped person. There are several basic principles underlying the process. These are:

1. Action must be based upon adequate diagnostic information and accurate and realistic interpretation of the information that is secured.

2. Each rehabilitation client must be served on the basis of a sound plan.

3. Guidance and counseling of clients and close supervision of all services are essential at each step of the process.

4. Each service must be thoroughly rendered and followed-up.

5. The cooperation and involvement of the client and all others concerned with his rehabilitation is necessary and must be secured before adequate rehabilitation can be accomplished.

6. Adequate records must be kept.

The process starts with the initial case finding or referral, and ends with the successful placement of the handicapped individual on a job. The unique characteristic which distinguishes and differentiates the vocational rehabilitation process from all other types of counseling is its insistence upon the realistic and permanent vocational adjustment of the handicapped individual as its primary objective.

Steps in the Process

Selection and Preliminary Client Study - The counseling interview is the basic method of securing information. The purpose of the interview is to help the counselor understand as much of the total personality of the applicant as may be necessary to assist in his vocational adjustment. As used in the case investigation the interview is not a routine form-filling exercise; it is a planned, but flexible, procedure for securing vocationally significant information, including the emotional significance to the client of his health, educational, vocational and social history. The information from the interview is fully recorded on interview forms or face sheets and supplemented by narrative recording. The exact form used will vary from State to State and from agency to agency.

The counselor needs to be thorough in reviewing the client's history and background and competent in handling difficult interviewing situations. The counselor should be objective at all times; he should accept attitudes, customs, and behavior patterns which differ from his own; he should be unbiased in his approach to an explanation of the client's situation. The counselor during the initial interview tries to determine whether the applicant is probably a subject for rehabilitation on the basis of the contact,with an understanding of and interest in vocational rehabilitation.

Evaluation of Client Study Data - As the starting point of the client study the information from the interview is an important factor in determining the types and amount of case information needed to supplement the client's history. These include the following:

1. Medical Evaluation - to establish the nature and extent of the disability (one step in determining eligibility); appraise the general (total) health status of the individual in order to determine his capacities and limitations; ascertain if physical restoration services might remove, correct, or minimize the disability condition(s); and contribute a sound medical basis for selection of a rehabilitation objective. Medical evaluation is a continuing or recurring activity throughout the rehabilitation process, not merely something undertaken as an initial step in the case study. It is a responsibility of the counselor to interpret to the client the reasons for the agency's requirement for medical examination; to explain what the individual may expect to have done to him in the examinations; and to explain what use will be made of the examining physician's reports in the rehabilitation process.

2. Social Evaluation - involves securing social history material which taken as a whole brings the client into focus as an individual distinct from others and points up his potential for benefiting from the rehabilitation process. Social

history is necessary for a diagnosis of the total problem and is the background against which planning and treatment are predicted.

3. Psychological Evaluation - results from a synthesis of psychometric data and information obtained during interviewing, counseling, and other aspects of the rehabilitation process. Psychological evaluation is not an isolated service but is closely related to counseling and all other rehabilitation services.

4. Vocational Evaluation - means to gather, to interpret, to analyze and to synthesize all the vocational significant data regarding the individual and to relate them to occupational requirements and opportunities. These include: relating work and vocational training history to present circumstances, considering the disability, age, employment opportunities, personal adjustment, mobility and family circumstances. It is important to relate the results of vocational evaluation in rehabilitation facilities to the needs of the individual.

Rehabilitation Diagnosis - The rehabilitation diagnosis means bringing together significant case data for the purpose of making evaluations with respect to eligibility, job selection, personal adjustment and job preparation and job adjustment. Three major factors are:

The identification of problems.
Determination of eligibility.
Vocational appraisal for purpose of selection of job objective.
Identification of rehabilitation services needed.

Planning Rehabilitation Services - In planning and making the necessary arrangements for the program of services the basic principle should be observed that the client needs to participate in the planning and assist himself as far as possible. The counseling relationship should be devoted to motivating and assisting the client to make the necessary contacts and putting into effect the program of service. The arrangements for services which are purchased or secured from agencies and other resources or facilities should be made by the counselor who acts as the official representative of the agency.

Selective Placement and Follow-up - Integral part of each plan; placement and follow-up complete the rehabilitation service.

The counselor should have a thorough knowledge of job opportunities in his area, and become familiar enough with job analyses to ascertain which jobs his client can perform efficiently. The counselor assumes responsibility for job placement and in this connection should interpret client's disabilities and abilities to employer; refer client to employment service; and inform client as to how to apply for a job. Placement planning should be done far enough in advance so that client can step into a job upon completion of other necessary rehabilitation services.

Evaluation of Placement - The work should be suitable and in line with the plan at the time of placement. The job duties, working conditions, wage rates, suitability for the client personally and in line with disability, client adjustment, employer satisfaction, and completion of all necessary services are key factors in the placement of the person in suitable employment.

SUMMARY

In any vocational rehabilitation program the core of the rehabilitation counselor's work is counseling. He accomplishes this function by maintaining a counseling relationship which serves to unify all rehabilitation services into an organized plan resulting in the client's reaching a maximum adjustment from all aspects--social, medical, psychological and vocational.

The counselor emphasizes the strengths of his client, rather than his weaknesses. In order for the client to reach his potential maximum it is necessary for the counselor to understand fully the vocational rehabilitation process. The securing of medical, social, psychological and vocational data should be viewed in the content of the client's overall experience in order to be meaningful.

The success or failure of a rehabilitation program is measured by the degree to which the client makes effective all of the new skills and psychological insights he has gained through the various steps in the rehabilitation process. In most instances, placement of a disabled person is, and should be, the final step in vocational rehabilitation. Therefore, provision for this service is an integral part of the process.

The vocational rehabilitation counselor assumes varying degrees of responsibility depending on his agency, his training, and the specialized type of service he can contribute in the different steps of vocational rehabilitation. In a State agency he functions most effectively as a professional person who integrates all services needed by the client for his rehabilitation, including those for which he arranges through purchase or referral.

The vocational rehabilitation counselor may have to subordinate his own drives and desires in order to develop close cooperation with other members of the rehabilitation team. He should work closely with physicians, physical, occupational, and speech therapists, social workers, psychologists, nurses, teachers, and other team members, but must at the same time, be cognizant of the fact that the focus of vocational rehabilitation should be on the client and not on the person doing the helping.

References and Suggested Readings

1. Bellows, R. M., Psychology of Personnel in Business and Industry. New York: Prentice-Hall, 1949.

2. Black, B. J., "Principles and Trends in Rehabilitation." Jewish Communal Service, 22:4, 351-355, 196.

3. Bordin, E. S., Psychological Counseling, N. Y., Appleton-Century-Crofts, 1955.

4. Burdett, Arthur D., "The Role of the Counselor." Habilitation Review. Occupational Center of Essex County, Inc., Newark, New Jersey: January - February 1960.

5. Caplow, T., The Sociology of Work. Minneapolis: University of Minnesota Press, 1954.

6. Cholden, L., "Some Psychiatric Problems in the Rehabilitation of the Blind." Bull. Menninger Clinic, 18:3, 107-112, 1954.

7. Counseling for Psychological Acceptance of Disability. Rehabilitation Service Series No. 260, Washington, D. C. Office of Vocational Rehabilitation.

8. DiMichael, S. G., "Characteristics of a Desirable Psychological Report to the Vocational Counselor. J. Consult. Psych. 6: 432-437, 1948.

9. DiMichael, S. G., (Ed.) Vocational Rehabilitation of the Mentally Retarded. Government Printing Office, Washington, D. C. 1950.

10. Dunning, Arthur, "Rehabilitation: A New Specialty?" J. Social Casework. 2, 1957.

11. Employing the Physically Handicapped: a Bibliography. Washington, D. C., U. S. Department of Labor, 1951.

12. Garrett, Annette, Interviewing--Its Principles and Practice. Family Welfare Association of America. New York, 1942.

13. Garrett, James F., "Counseling the Man--Not the Disability." The Crippled Child, April 1952.

14. Garrett, James F. (Ed.) Psychological Aspects of Physical Disability. Washington, D. C., Office of Vocational Rehabilitation, 1952.

15. Ghiselli, E. E., Brow, C. W., Personnel and Industrial Psychology. New York: McGraw-Hill, 1948.

16. Guide for Employers in Hiring the Physically Handicapped, New York: National Association of Manufacturers, 1955.

17. Hall, James H., Warren, Sol H., Rehabilitation Counselor Preparation. Washington, D. C.: National Rehabilitation Association, National Vocational Guidance Association, 1956.

18. Hamilton, Kenneth, Counseling the Handicapped in the Rehabilitation Process. New York: Ronald, 1950.

19. Interview Guides for Specific Disabilities. Washington, D. C.: United States Employment Service , 1954.

20. Jacobs, A.,"Training Facilities for Severely Physically and Mentally Handicapped." American J. Mental Deficiency. 60: 4, 721-728, 1958.

21. Lofquist, Lloyd H., "An Operational Definition of Rehabilitation Counseling." J. of Rehabilitation. 1959, Vol XXV, No. 4.

22. Maier, Norman R., Psychology in Industry. Boston: Houghton-Mifflin, 1955.

23. Meislin, J., "The Psychiatric Sheltered Workshop." Arch. Phys. Med. and Rehabilitation. 20: 3: 224-228. 1954.

24. New Hope for the Disabled, (Public Law 565, 1954), Washington, D. C. Office of Vocational Rehabilitation, 1959.

25. Patterson, C. H., "Counselor or Coordinator?" J. of Rehabilitation. 1957, 23.

26. Pattison, Harry A. (Ed.) The Handicapped and Their Rehabilitation. Springfield, Ill., Charles C. Thomas, 1957.

27. Psychiatric Information for the Rehabilitation Worker. Washington, D. C., U. S. Office of Vocational Rehabilitation, 1950.

28. Selected Placement for the Handicapped. Washington, D. C. U. S. Employment Service, 1945. Revised Ed.

29. State Workmen's Compensation Laws as of September 1954. Washington, D. C.: U. S. Department of Labor, 1955.

30. Super, Donald E., Appraising Vocational Fitness, by Means of Psychological Tests. New York: Harper, 1949.

31. The Physically Impaired; a Guidebook to Their Employment. New York: Association of Casualty and Surety Companies, 1952.

32. Thomason, Bruce and Barrett, Albert M., (Editors) Casework Performance in Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, 1959.

33. Traxler, A. E., Techniques of Guidance.New York: Harper, 1945.

34. Tyler, Leona, The Work of the Counselor. New York: Appleton-Century-Crofts, 1953.

35. Worker Trait Requirements for 4,000 Jobs. U. S. Department of Labor, Washington, D. C.

36. Zerfoss, Karl P., Readings in Counseling. New York: Association Press, 1952.

37. Hunt, Joseph. "Impact and Potential of Rehabilitation." New Outlook for the Blind, October 1959.

IDENTIFICATION OF PERSONS IN NEED OF REHABILITATION SERVICES

In the administration of any type of service to individuals, such as vocational rehabilitation, it is imperative that the persons in need of services and the community resources providing such services be brought together. Case finding is the process of acquainting the public with the objectives and services of the rehabilitation agency; locating all disabled individuals in need of and who might be eligible for vocational rehabilitation services; informing them of the services available through the vocational rehabilitation agency; and finally ascertaining whether they are interested in receiving such services. This process involves acquainting the public with the objectives and services of the rehabilitation agency; reaching the disabled through any and all media available to the agency; interpreting the objectives and services to community resources which normally serve disabled people; and promoting the development and maintenance of specific channels for helping the disabled to reach the rehabilitation agency as early after disablement as may be feasible, in light of the factors involved in the disability.

When a disabled person has made application providing the minimal data identifying him, the nature of his disability, his location, and the referral source, he then becomes a vocational rehabilitation referral no matter what the specific vehicle was which brought him to the agency.

The process of identifying clients in need of rehabilitation services should meet the following criteria:

1. It needs to fulfill the concept that every disabled individual is entitled to know about available vocational rehabilitation services and to consider them according to his needs and interests.

2. It needs to be realistic in providing for suitable referrals on the basis of a true understanding of the general objectives and services that the agency is equipped to provide.

3. The referral needs to be made early in the period of disablement. This provides for contact with the client when he is more receptive psychologically and physiologically to rehabilitation measures. This allows more time for provision of effective planning and services, thus lessening the compounding of adjustment problems through delay.

4. It needs to be aggressive and active to keep referral channels open and referrals flowing from all potential sources.

5. It needs to promote greater exchange of information and closer coordination of services for the disabled in the community. This characteristic is often an outcome of the application of principles listed above, since the personnel of the agency involved in making the referral and the personnel of the rehabilitation agency work together with a focus on client needs.

6. It needs to represent good public relations techniques. Such a process encourages community understanding and helps provide a better community climate, in which a recognition of the problems of disablement are approached with realism and in context with broad community planning for welfare and health needs. Mutual respect, with all that it implies, is thus developed and promoted between referral agency personnel and personnel in the rehabilitation agency.

Development of Referral Sources

Community organization techniques are used to promote community awareness of the needs of the disabled and an understanding and acceptance of rehabilitation concepts and practices. This is done to promote wide-spread interagency cooperation toward the common goal of the vocational rehabilitation of the handicapped persons living within the community. In terms of interagency relations, several variables need to be considered. It is generally necessary to reach formal agreement on areas of responsibilities that originate at various operational levels in any public or private agency; to develop good inter-personal staff relationship among agencies; to establish a regular method of exchange of information and inter-office visits; to make the training facilities in the community available to related programs; to make use of joint staffing of cases when appropriate; and to enlist the community support for the rehabilitation program.

Suggested Techniques for Case Finding

There are certain basic techniques that the counselor should observe in case finding. Responsibility to both prospective clients and referring agencies should be essential characteristics of this procedure. Listed below are several principles involved in good case finding procedures.

1. Maintain an attitude of expecting referrals.

2. Make referral procedures convenient and as easy as possible within the limits of effectiveness and agency policy.

3. Provide preliminary evaluation as a basis for acceptance or rejection of referrals. Advise all parties concerned about decisions that were reached and why they were reached.

4. Develop prompt reporting back procedures to the original referral source.

5. Examine flow and classifications of referrals from source periodically using your agency.

6. Maintain records on referrals for evaluation, follow-up, and possible research appropriate to your area of work.

Sources of Referrals

Persons served by State vocational rehabilitation agencies come principally from the following sources: doctors, hospitals and clinics; public and voluntary welfare agencies; self-referred; educational institutions; other individuals; public employment service; artificial limb companies; employers and labor unions; television, radio, and news items; BOASI; Veterans Administration; and other rehabilitation agencies.

References and Suggested Readings

1. Becht, Helen, The Development of Adequate Referral Through Interagency Cooperation. New York: National Council on Rehabilitation, 1946.

2. Hamilton, Gordon, Theory and Practice of Social Casework. New York: Columbia University Press, 1951.

3. Hamilton, Kenneth W., Counseling the Handicapped in the Rehabilitation Process. New York: Ronald Press, 1950.

4. Hillman, Arthur, Community Organization and Planning, New York: MacMillan Company, 1950.

5. MacDonald, Mary, Federal Grants for Vocational Rehabilitation. Chicago: University of Chicago Press, 1944.

6. McMillen, Wayne, Community Organization for Social Welfare. Chicago: University of Chicago Press, 1945.

7. Sanderson, Herbert, Basic Concepts in Vocational Guidance. New York: McGraw-Hill, 1954.

PART TWO

THE REHABILITATION CLIENT-STUDY PROCESS

The purposes of the preliminary phase of the client study process are to ascertain whether or not the applicant may be a subject for rehabilitation services and if further investigation is indicated. The preliminary study eliminates many people who have heard about the service and merely want to know more about it, or who have been referred by misinformed people and are definitely not eligible for services. The information sought during the preliminary study consists of the name and address of the person, the date of referral, the source of referral, his age, and a statement of disability. These facts provide the basis for determination as to acceptance or non-acceptance on a very tentative basis and point out what additional information is needed. Thus, they set the stage for further study from many other sources.

During the preliminary study the principal source of information is the client himself. The interview serves as a major source of contact at this point. It introduces the individual to the agency, its purpose, services and objectives, and relates this information to his individual situation. During the preliminary interview the counselor should obtain a statement of the applicant's problems; give an explanation of the overall functions of the vocational rehabilitation program; confirm the applicant's desire for rehabilitation services; record and evaluate the pertinent facts and data obtained; and identify the areas of study requiring further exploration.

The initial interview should follow as quickly as possible after the referral is made to the agency. The setting may be in the counselor's office, in another agency, in a hospital, or in the individual's own home. Wherever the initial interview is held the basic purposes outlined above should be followed.

The end result of the preliminary study should be the beginning of the establishment of a sound counselor-client relationship. The rehabilitation counselor should be careful to maintain a sound balance between his own personal needs and interest in the case and the aims and policy of the agency for which he works. He can accomplish this by explaining with sympathy and understanding the legal limitations of the agency and the procedural requirements which the client must follow in order to qualify for service. He identifies himself with the agency in respect to these limitations and requirements and should not apologize for them. While the counselor should attempt to show a sympathetic understanding of all the client's problems and requests, he nevertheless must deal with reality factors involved in the situation and make clear to the client the kind of help that he is in a position to give and what his agency can provide. In short, he operates within the general framework of his agency.

The expected results of the first interview are as follows: the client should feel free to express himself; the client should leave with the feeling of satisfaction that he and the counselor will do all that they can to work out a satisfactory solution to his problem; rapport

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should be established to the point that the client is beginning to feel free to talk about personal problems and to express feelings of fear, hostility and inadequacy without fear of reprimand. On the other hand, the counselor should have been able to accept the feelings of hostility and negativism expressed by the client and not to evaluate them in terms of a socially approved middle class value system. He should recognize, accept and encourage the client's need and feelings for independence and do all that he can to make the client feel accepted and understood.

Counselor Techniques During the Initial Interview

In order to accomplish these things, the counselor should practice to the best of his ability sound counseling techniques. He should avoid being authoritative and yet at the same time keep the reality factors of the situation in mind. He should be frank, and yet sensitive enough not to offend the client. He should help the client face his problems realistically and at the same time be capable of understanding and accepting the severe feelings of emotional stress which accompanied disability and traumatic injury. He should attempt to get at the facts and be able to distinguish relevant from irrelevant data. He should present facts in such a way that the client is able to see them objectively and deal with them realistically. He should avoid either encouraging or discouraging the client beyond the facts that he has at that particular time.

In terms of specific counseling techniques, there are several dangers inherent within any preliminary interview survey structured around the use of a survey questionnaire as used in rehabilitation. These involve the preliminary interview becoming a mere question and answer type interview in which the counselor asks specific questions and the client responds with specific information. In order to avoid these dangers, the counselor should be careful about asking questions which the client can answer with a specific "yes" or "no." Rather, he should present material in such a way that the client feels free to respond and to develop his answers in detail. If questions are asked, they should be asked one at a time, and in a general rather than specific sense.

Since counseling represents a learning situation the counselor must be aware of the fact that the client begins to "learn" what is expected of him during the initial part of the interview. As a result he must be careful to structure the initial interview in such a way that the techniques used will be equally profitable during later phases of the counseling contact. He must learn to feel at ease with pauses and periods of silence which are productive as far as client thought and interaction are concerned. He must learn to control his own emotional reactions and give the client the freedom that he needs in order to express himself during the initial interview. He must communicate to the client, both verbally and nonverbally, feelings of warmth, understanding, acceptance, lack of personal evaluation and set up a situation free from any feelings of personal threat. He must not attempt to play a role or to change his own pattern of natural verbal responses to fit any particular counseling techniques, rather he should adapt a counseling technique to his own verbal

delivery pattern. He should communicate to the client a real interest in him and a real willingness to help.

In most cases it is not necessary to "tell" the client what counseling is since he will experience it within the relationship and learn from what the counselor does as well as from what he says. The counselor must learn to increase his ability to listen and observe. Counseling is built around the techniques of observation and observation should become one of the main tools of the professional counselor. In this regard, the counselor needs to learn to respond to minimal cues expressed through the client's behavior, and to listen not only to what he says but to observe quite closely his reaction to the material that he is discussing.

In the field of rehabilitation counseling more than in many other areas, he needs to learn his own limits, and to develop his capacity to control personal reactions to extreme disfigurement and disability, as well as to extremely difficult problems and environmental situations. In a sense, it is necessary for the counselor to give a good deal of himself personally in order to communicate anything to the client, and yet at the same time he must avoid becoming "overidentified" with the very difficult problems that he will encounter in the day-by-day work of a rehabilitation agency. He must maintain a happy balance between an interest in helping the client, at the same time not making the problems of the client his own. He must remember that his obligation is to many clients, and that he must maintain an objective and realistic balance between the time and the service that he can give to any one client of the agency. In a sense, in order to be able to help clients, he must know himself, his limits, his capaoities, his strength and his weaknesses.

This section should serve as a guide to counselors in applying established standards related to the medical aspects of client study and diagnosis. It also presents recommendations for obtaining adequate medical evaluation, including suggestions with respect to the responsibility of the medical consultant.

Purpose of Medical Diagnosis

The major purposes of the medical diagnostic study and evaluation in vocational rehabilitation are:

1. to establish, through competent medical judgement, that a physical or mental impairment is present which materially limits the activities which the individual can perform, as one aspect of determining the individual's eligibility for services as a "disabled" person;

2. to appraise the current general health status of the individual, including the discovery of other impairments not previously recognized, with a view to determining his limitations and capacities;

3. to determine to what extent and by what means the disabling condition can be removed, corrected or minimized by physical restoration services; and

4. to provide a realistic basis for selection of an employment objective that is commensurate with the disabled individual's capacities and limitations.

Although the diagnostic phase of the rehabilitation process is, in most cases, concentrated time-wise in the early period of the case, the diagnostic study of the client continues throughout the period of rehabilitation services as well. Medical diagnostic services may be needed in some cases long after eligibility has been established and rehabilitation services have been initiated. Changing conditions in the client's life or physical status may at any time necessitate re-evaluation of the need for rehabilitation services; there may be need for further diagnostic study as a result of the changed health picture; another medical opinion as to the desirability of medical or surgical treatment may be advisable; or the suitability of the employment objective may need to be reconsidered.

Individuals receiving services over long periods of time should have at least an annual medical examination which is comprehensive enough to provide information as to the individual's current total health situation.

Range of Medical Diagnostic Services

The counselor on the advice of his medical consultant should arrange for all the medical diagnostic services that are required for an adequate understanding of the individual, his present and probable future health status, his needs for medical care or other rehabilitation services, and his capacities, or limitations, for employment.

Included in the broad range of such diagnostic services are:

1. Medical and surgical examinations
2. Psychiatric evaluations
3. Dental examinations
4. Consultation with and examinations by specialists in all medical specialty fields
5. In-patient hospitalization for study or exploration
6. Clinical laboratory tests
7. Diagnostic x-ray procedures
8. Trial treatment (especially in cases of epilepsy, diabetes mellitus, emotional disturbances, or for differential diagnosis in other conditions)
9. Other medically recognized diagnostic services.

Preparation for Medical Diagnostic Study

At the point of initial contact with the client, the counselor in consultation with his medical consultant should begin to make careful plans for the way in which the medical diagnostic study will be undertaken. As a part of the early history-taking, the counselor should secure from the client information about his disability, its onset, its symptoms; its remissions (if any), and the treatment he has had for it and other significant past illnesses.

Particularly important is adequate information about the client's current medical supervision. If he is under the continuing care of his own physician, the counselor will wish to know the nature of the treatment being provided, the recency of the contacts, and the nature of the doctor-patient relationship. Outstanding medical debts may be a factor in the client's relationships with his doctor or in his use of medical care. If the physician knows the client well, he may contribute much to an understanding of social and psychological aspects as well as medical aspects in the client's situation.

If the client is receiving medical supervision from a hospital or clinic in the community, it is important for the counselor to know of those relationships. These should be taken into consideration by the counselor and his medical consultant in planning and arranging for medical diagnosis or physical restoration. In many instances the medical data included in referrals from physicians or health agencies should be supplemented by more detailed resumés of medical services that have been provided.

At the same time that the counselor is studying the medical aspects of the client's situation, he should be securing significant data regarding the client's social relationships and vocational history as steps toward determining whether or not an employment handicap exists. In determining the extent of the employment handicap, the counselor should make at least a preliminary and tentative application of his knowledge of employment opportunities to the client's situation.

An integral part of the counseling process is the counselor's preparation of the client for what he may experience during the medical diagnostic study. Adequate interpretation of the agency's requirements and reasons for those requirements, and of the reasons for the diagnostic procedures is essential for establishment of rapport and for enlisting the client's cooperation in following through on medical recommendations. The client will need to understand why he is being referred for medical examinations, the amount of time they may require, what he can and cannot expect to learn from the examining physician, and what use the agency will make of reports of his medical condition. In some cases the knowledge that the agency is purchasing medical examinations on a "private patient basis" may be a potent factor in the client's acceptance of medical recommendations and influence his motivation for independent living.

The General Medical Examination

Purpose. The medical examination done by a general physician who takes an over-all look at the total medical problem of the individual, insofar as he is able, is an examination of great potential significance in case diagnosis and rehabilitation planning. The purpose of the general medical examination, in most cases, is to begin an evaluation of the individual's total medical problem and to establish his current health status. In some cases, however, a specialist's report of the individual's obvious impairment may precede the general medical examination; occasionally a psychiatric examination or psychological testing may appropriately take place before the general medical examination.

Regardless of the type of impairment (an amputated limb or a metabolic disorder, for example), it is important to secure complete data regarding the individual's sight, hearing, muscle tone, skin, heart, lungs and other factors that might have a bearing on the choice of the occupational objective, the way he may impress prospective employers, or his functioning on the job.

Clients who have been treated in mental hospitals, tuberculosis sanatoria, or specialized outpatient clinics are often in need of a general medical review of other bodily systems; and there is particular need for visually

impaired persons to have eye examinations supplemented by medical review of other sensory systems and the total physiological and bodily functioning.

Choice of the examining physician. The counselor and his medical consultant will need to plan how the medical resources of the community can best be used in each case. Many clients who come to the agency are already under the care of physicians, hospitals or clinics. If the client has his own family physician, the counselor should encourage the continuance of such a doctor-patient relationship. More valid medical data may well be obtained from the family doctor than from a new medical examiner. Any consideration of change of examiners in the interest of a fresh appraisal of the client, or of the desirability of supplementary specialist's examinations should be carefully discussed with the family physician and his cooperation secured, if possible. In some instances it may be advisable for the medical consultant to discuss the client's rehabilitation plan with the individual's family physician.

Good resumés which provide a history of past, and continuing, medical care are essential in planning the diagnostic services that the counselor should secure. Frequently a resumé from a hospital or clinic will report the results of elaborate, expensive diagnostic procedures already performed, and thus make it unnecessary for the state agency to repeat such tests, thereby saving funds. Resumés also provide necessary information about past medical treatment or previous surgery and their results that can be secured only through such reports.

In spite of the emphasis in the preceding paragraph upon the importance of resumes of past medical care, there is great need for understanding the present medical condition of the individual in relation to the purposes of the vocational rehabilitation program, which often can be achieved only through new and thorough examinations.

In many cases coming to the counselor, it will be important to secure a completely new, thorough, medically objective, fresh evaluation of the client if vocational rehabilitation is to provide an opportunity for a new effort at useful living. The possibility of uncovering sound medical reasons for the individual's ill health which had been previously overlooked has been repeatedly demonstrated when more medical time and interest have been made available to him. Since many VR clients are those who have not been helped through the usual channels of medicine, education or employment, the counselor often must be prepared to provide more and better services than have ever been available before, at least at any one time. Through a new medical diagnostic look, it may be possible to catch an error in diagnosis or an overlooked clue.

In cases in which current medical examinations to clarify the individual's present physical status and future prognosis for work are

considered necessary but cannot be secured, it is questionable that rehabilitation services should be initiated until the medical problem has been satisfactorily settled. Difficulties in securing a current medical evaluation may arise when the client refuses further examination, when the attending physician is reluctant to share medically descriptive information, and when it seems unwise to pursue further diagnostic study for a variety of reasons. Such difficulties seriously hamper sound rehabilitation planning by the counselor and the client. The medical consultant can be extremely helpful in securing cooperation from the client's physician.

Whatever physician is selected by the counselor and the client to perform the general medical examination, it is important that the examining physician understand the agency's function and objectives, so that he will be aware of what the agency expects from him and what kind of information will help the counselor do his job most effectively.

Both the counselor and his medical consultant can be helpful in interpreting to examining physicians what kind of medical information is needed by the agency as a basis for rehabilitation planning. The counselor can give to the examining physician concrete information about work requirements for various occupations or specific jobs, as well as information about conditions of work which can be used in appraisal of the individual's physical capacities.

Some counselors have found it helpful to send the request for the medical examinations over the medical consultant's signature, and to request that the examination findings be returned to the medical consultant for review. Similarly, counselors have found it advantageous to have the authorization for the examination (signed of course by the appropriate official charged with such responsibility) accompanied by a letter from the medical consultant which requests answers to specific questions.

Scope of the General Medical Examination

The general medical examination should consist of a medical history and a complete physical examination. The examination should cover the individual'a general appearance, weight, height, posture, blood pressure, pulse, respiration, hearing, vision, blood vessels, lymph nodes, extremities, heart, lungs, pelvis, nervous system, and other parts of the body specifically mentioned on the state agency's examination form.

Certain clinical laboratory tests are considered an indispensable part of any general physical examination. Urinalysis is so viewed and should be required. A serological test for syphilis and a chest x-ray are now also widely accepted as minimal elements in a general medical examination. It is recommended that such tests be procured in each case. Other laboratory tests recommended as desirable for routine inclusion in the general medical examination are a blood count, consisting of at least a red and white cell count and a hemoglobin determination, and an electrocardiogram for clients over 40 years of age. In most instances these

tests would involve additional fees beyond the rate for the general medical examination.

The simple urinalysis for sugar or albumin has been most useful in discovering unsuspected cases of diabetes or kidney disease. Serology is indispensable in serving persons with long-standing chronic illness. Chest x-rays are valuable in revealing heart pathology, as well as the presence of tuberculosis, tumors, and other pathological conditions of the lungs and chest. The purpose of such diagnostic tests is to give a better understanding of the particular individual whom the counselor is considering serving.

Recency of General Medical Examination

The general medical examination should be recent enough to provide an adequate basis for evaluating the individual's present state of health and for planning what he should appropriately undertake by way of training or work activity. In most cases, new examinations should be procured if medical data are older than three months. This suggested time period may vary from one disease condition to another. It may be lengthened for certain individuals; but in some cases, such as diabetes, anemia, or certain heart conditions, it is important to have current (no older than one month) data as to the individual's status. In all cases it is desirable that the medical consultant evaluate both the content of the medical information secured from examining physicians and its adequacy in terms of recency.

Acceptance of Medical Resume

If a medical abstract or resume of medical care and examinations is available to the counselor, the following conditions should be met if it is to be considered the equivalent of a new general medical.

1. The client's total condition should be reported upon, rather than merely a portion of his anatomy. The data requested in the general medical examination report form should be covered in the resume.

2. The resume should indicate the date on which the examination was done -- when the blood pressure readings were taken, etc. A report which merely summarizes treatment of a series of acute illnesses, or one which is merely filled in from the physician's records without evidence of a complete examination, is not an acceptable substitute.

3. The medical findings and conclusions should be of sufficiently recent date to warrant their use in planning for the individual's rehabilitation.

4. It is wise to have requests for medical information to examining physicians go out over the medical consultants' signatures.

Specialty Examinations

Examinations by a specialist in one or more medical specialty fields should be secured in all cases in which there is need for a more thorough study of the particular impairment or bodily system in which the impairment lies, in order to secure a better understanding of the client's condition, possibilities of treatment, and rehabilitation potentialities. These should usually be done upon recommendation of the medical consultant.

Hospitalization for Diagnostic Study

In-patient hospitalization for diagnostic purposes should be provided in cases in which the diagnostic study required for an adequate understanding of the client's condition cannot be satisfactorily done on an out-patient basis.

In order to minimize unnecessary costs of hospital care, the counselor should plan carefully the timing of the client's admission to the hospital. For example, a hospital's clinical laboratories and other supporting diagnostic services rarely provide, over a weekend, the full services necessary for intensive study of a patient; therefore, it is desirable that the client be admitted to the hospital when its full resources can be most effectively and economically utilized.

Responsibility of the Medical Consultant in Interpretation of Medical Findings

The medical consultant should be especially concerned with interpreting the significance of medical findings to counselors and other state agency personnel involved in rehabilitation planning. Even though the counselor may have discussed the client's physical capacities and limitations with the examining physician and even though the latter may have concurred with the employment objective, the medical consultant is in a position to offer sound advice from the agency's viewpoint. Moreover, he is in a better position to know and appraise the total medical findings regarding the client than a single examining physician, who might be unaware of other significant factors in the case.

Finally, the medical consultant has a responsibility to make sure that the client understands his medical situation and the treatment plan, if any. The medical consultant and the counselor should jointly plan arrangements for suitable interpretation to the client and his family of the medical data that are essential for their full and positive cooperation in the rehabilitation plan. Such interpretation may be provided by the counselor, the agency's medical social consultant or medical consultant, but preferably by the examining physician in many instances. The counselor may find it desirable to arrange for the client to make a return visit to the physician to secure this interpretation.

The counselor has basic responsibility for seeing that all necessary services are provided to the clients in his caseload, and for requesting medical consultation on all problems for which there is a need for medical advice.

While the medical consultant has a responsibility for providing medical advice he also has a corollary responsibility for initiating consultative interviews with the counselor on troublesome cases. Particularly in cases presenting difficult or complicated diagnostic problems, the medical consultant needs to assure himself that the client is being adequately studied. There will also be cases, such as severe anemia, uncontrolled diabetes, or suspected malignancy, in which diagnostic examinations indicate the need for prompt action in getting the client immediately under appropriate medical care. In the event that the counselor does not intend to provide appropriate medical care through the agency, he has an obligation to see that the client, or a responsible member of his family, receives an interpretation of the urgency of need for treatment. The medical consultant will prove helpful in calling such cases to the attention of the counselor in charge of the case; in some instances interpretation of the need for treatment should be made by the physician in charge of the case.

References and Suggested Readings

1. Description of Common Impairments. U. S. Department of Health, Education, and Welfare, Bureau of Old-Age and Survivors Insurance, Washington, D. C.: 1959.

2. Disability and Social Security, U. S. Department of Health, Education, and Welfare, Bureau of Old-Age and Survivors Insurance, Washington, D. C.: 1958.

3. Handbook for Medical Consultants in the State Vocational Rehabilitation Program. U. S. Office of Vocational Rehabilitation, Washington, D. C.: revised 1957, 146 pp.

4. Lowry, L. G., Psychiatry for Social Workers, New York: Columbia University Press, 1948.

5. OVR Manual, Chapter 16, Section 2, Standards of Medical Diagnosis (1955).

6. OVR Manual, Chapter 16, Section 4, Standards of Dental Diagnosis (1956).

7. OVR Manual, Chapter 19, Physical Restoration Services (1956).

8. Psychiatric Information for the Rehabilitation Worker, U. S. Office of Vocational Rehabilitation, Washington, D. C.: 1950.

The psychological evaluation of a client forms an integral part of the case study process. Evaluation involves more than mere psychological testing. It includes the study of the client's past behavior as well as conclusions drawn from observations of his current behavior during the initial interview and outside contacts. The evaluation of the client's behavior is in no way limited to the preliminary phase of the study but continues during the entire rehabilitation process. The sensitive rehabilitation counselor is continually checking his observations and predictions against the client's overt behavior and modifying counseling techniques and possibly even tentative job objectives on the basis of these observations.

The rehabilitation counselor bears the responsibility for determining both the need and extent of psychological evaluation. It is his job to provide either directly for the evaluation, if trained to do so, or to secure the information from other sources. In most rehabilitation agencies, psychological evaluation may be provided by the counselor himself, by psychologists on the state staff, by consulting psychologists on the state staff, or by outside psychologists if they have special training in the area of diagnostic work with the handicapped. Nevertheless, the ultimate responsibility for the application of the information obtained lies with the counselor. He is professionally obligated to make use of the information gained during the psychological evaluation to help the client know and understand himself and to help him in arriving at a reasonable vocational objective. During the initial phase of the case study the psychological evaluation provides valuable information in the determination of eligibility and feasibility.

Values of Psychological Evaluation

DiMichael, in a pamphlet (13) entitled "Psychological Services in Vocational Rehabilitation", lists the potential values of psychological evaluation to the client as: " (1) a counseling aid to the client in understanding himself; (2) a counseling aid to the client in making reasonable plans and decisions; (3) a counseling aid to the client in identifying problems; (4) a counseling aid to the client in understanding his relative strengths and limitations."

The client's possession of such understanding aids the rehabilitation counselor, since the better the client understands himself the more able he is to deal reasonably and realistically with the counselor in the establishment of a vocational objective.

In the majority of cases, the money spent on psychological evaluation represents a sound investment to the rehabilitation agency involved. It is much easier to spend a few dollars on adequate evaluation than it is to waste a great deal of time and money as the result of an unrealistic vocational plan. Adequate evaluation should result in an

increased number of successfully rehabilitated cases. Psychological evaluation will help both the counselor and the client to identify special skills and aptitudes and supplement the subjective information which has been gathered during the initial phase of the client study process. It should help the counselor identify those clients who will need extensive counseling services as opposed to clients who are relatively psychologically intact, or are adjusting well to their disability, and who, therefore, will need only minimal counseling services during rehabilitation. This means that the rehabilitation counselor can devote his time to the client who needs it the most and by so doing increase individual client's chances for successfully completing a rehabilitation program.

Referral and Testing Problems

Many of the clients who are referred to vocational rehabilitation have recently experienced traumatic disability. The majority of them are men who have been self-sustaining for a number of years. Often times, almost over-night, they find themselves unable to work and desperately in need of help and assistance. In seeking such help they often over-react and sometimes strike out quite desperately at the person or agency attempting to help them. The rehabilitation counselor working in the area of psychological evaluation must realize that much of the hostility that the client is expressing is directed against the situation and not against him personally. Often times when the need for a series of psychological tests is mentioned to such a client he tends to react to the negative implications of testing and is unable to see how it can make any positive contribution towards his rehabilitation. Some people with very limited knowledge of the aims of psychological testing will be quite suspicious of the process and often times feel that the counselor is trying to find out, "if they are nuts." In order to overcome this, the counselor must have a very clear understanding of the specific aims of testing and psychological evaluation. He must establish rapport with the client so that he is able to explain to him the positive results which can come about as a result of the information which will be obtained. While he should certainly not attempt to "sell" the client on the value of the tests, he should present the material realistically and objectively and in such a manner that the client himself can come to see the values of the testing procedure.

There are many rehabilitation clients who present very difficult problems of testing. These include persons with cerebral palsy or muscular distrophy, serious impairments of arms and hands, impairments of vision, as well as clients with speech and reading difficulties. The counselor should exercise every caution to make sure that the test scores he receives are a true measure of the client's ability and interests, or whatever it is the test was designed to measure. The testing of the person with multiple handicaps or the cerebral palsied requires extensive training equipment and experience on the part of the person doing the testing.

Psychological testing services are needed when:

1. Long-term or expensive training is involved in a rehabilitation, that is,

   a. The job-objective under consideration involves college or university training.

   b. The job-objective involves more than three months' apprentice or on-the-job training.

   c. The client's vocational background is not in the field of the skilled work for which he is being considered.

2. Mental retardation has to be determined, that is,

   a. The applicant's eligibility for rehabilitation is based on mental retardation as the primary disability.

   b. The applicant is suspected of having sub-normal intelligence as a secondary disability.

3. Client or counselor needs information or confirmation of the client's abilities, aptitudes, achievements interests, and personality patterns, that is,

   a. The counselor or client is undecided about a vocational choice and desires information about the client's abilities, aptitudes, achievements, interests, and personality;

   b. A tentative job choice has been made, which the counselor or client wishes to confirm through psychological evaluation;

   c. The job choice of the client is considered unsuitable by the counselor, who then seeks objective confirmatory data on which to clinch the tentative decision.

4. Data on the client's capacities and abilities are lacking, are ambiguous, or are contradictory, that is,

   a. There is no educational or work record available on the client;

b. The case history shows serious contradictory data in regard to the client's capacities and abilities, and his expressed vocational interests.

5. Important talents, capacities, abilities or disabilities are suspected by the counselor or client, that is,

   a. A special talent or capacity is suspected, but the case history shows no reliable evidence of its existence; psychological tests are available for measuring such a talent;

   b. The counselor or client suspect the latter has a specific disability which will materially affect his successful pursuit of the vocational objective, for example, a reading disability, arithmetical disability, a deficiency in English and grammar, etc.;

   c. The client or counselor seeks to establish the equivalent of a certain level of education for the client, but he does not have the formal credits necessary to substantiate his claim, and the level of achievements as determined through psychological tests are necessary to attain the job objective in the most expeditious way.

6. An individual is known or suspected of having certain disabilities that require specialized evaluations of his capacities, abilities, skills, interests, and personality, that is,

   a. Persons with actual or suspected brain or head injuries, cerebral palsy, epilepsy, or other conditions involving neuromuscular disorders;

   b. Persons who have emotional disturbances, or for whom it is desirable to determine whether a psychiatric consultation is indicated;

   c. Persons who have or are suspected of having damage to the central nervous system;

   d. Persons with other disabilities which require specialized individual testing, such as the mentally retarded, the blind, the totally deaf and seriously hard of hearing, the aphasics, those with severe reading disability, problem cases and individuals whose employment record indicates they are "accident-prone."

Psychological diagnosis and evaluation may not necessarily be required when:

1. The person has very recently been successfully employed and intends to return to his work as soon as physical restoration services have been rendered;

2. The person has been successfully employed, is now unable to find similar work because of the prejudice of employers toward the handicapped, and it is necessary for the counselor to convince the employer that the client has the abilities required for the position;

3. The person has been successfully employed, and only a minor shift is contemplated in the type of work that he will do in the future;

4. The person has a long and rich background of information on jobs held; the jobs are in related types of work, and the individual has changed jobs for reasons beyond his control;

5. The individual has a long and rich background of educational information, the caliber of the school in which he matriculated is well established, the caliber of the teachers in important subjects is well established, and the client does not plan to study or work in areas unrelated to his background.

6. The individual is not cooperative and does not desire to be tested. In such cases, testing occasionally may be contraindicated until the reasons for such an uncooperative attitude are understood and dealt with in counseling. If the client becomes willing to see the psychologist, the latter may be able to evaluate his abilities and his personality patterns.

Counselor's Level of Competence and Ethical Problems Involved in Testing

The Committee on Ethical Standards in the Distribution of Psychological Tests and Diagnostic Aids of the American Psychological Association (2) suggests three general levels of competence are involved in using and interpreting psychological tests. Since this is an official report of this committee it is reported directly:

> Principle I. - Tests and diagnostic aids should be released only to persons who can demonstrate that they have the knowledge and skill necessary for their effective use and interpretation. Tests can be classified in the following categories, and should be released as follows:

Level A. Tests or aids which can be adequately administered, scored, and interpreted with the aid of the manual and a general orientation to the kind of organization in which one is working. Examples: educational achievement, trade, and vocational proficiency tests.

Such tests and aids are appropriate for use and interpretation by responsible, educated, non-psychologists such as school principals and business executives.

Level B. Tests or aids which require some technical knowledge of test construction and use, and of supporting psychological and educational subjects such as statistics, individual differences, the psychology of adjustment, personnel psychology, and guidance. Examples: general intelligence and special aptitude tests, interest and personality screening inventories:

1. Can show that they have had such training;

2. Are employed and authorized to use them in their employment by an established school, government agency, or business enterprise;

3. Are enrolled in a course for the study of such instruments;

4. And, in instances 1, 2, and 3 above, are members of, or are vouched for, by a member of the American Psychological Association, or of an officially cooperating professional association with related interests and comparable standards.

Level C. Tests and aids which require substantial understanding of testing and supporting psychological subjects, together with supervised experience in the use of these devices. Examples: Clinical tests of intelligence, personality tests, and projective methods. Such tests and aids are appropriate for use only by:

1. Members of the American Psychological Association who are Diplomates of the American Board of Examiners in Professional Psychology or Fellows in appropriate Divisions.

2. Members of the American Psychological Association, or persons, with at least a Master's Degree in Psychology, who have had at least one year of supervised experience under a psychologist who is a Diplomate or Fellow in an appropriate Division, or, in the case of persons who received the MA prior to 1950, who have had supervised practice under a person with training equivalent to that required for Fellowship in an appropriate Division of the American Psychological Association;

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3. Members of the American Psychological Association who do not qualify under 1 or 2 above, but who are using tests for research or self-training purposes, with suitable precautions;

4. Graduate students who are enrolled in courses requiring the use of such devices, under the supervision of a psychologist with the qualifications described in 1 or 2 above;

5. Members of kindred professional associations who can show that they have had adequate training in clinical testing, including both theory and supervised practice in administration, scoring, and interpretation; comparable to that stipulated above for psychologists;

6. Teachers, graduate students, or other professional persons in psychology and related fields, who have had training and supervised experience in administering and scoring the test in question, and who administer the test to assist in the clinical or research work of a person qualified to interpret the test results as specified in 1, 2, or 5 above.

Principle II. - Persons purchasing tests, assuming responsibility for testing programs, or distributing tests, should be governed by recognition of the fact that being qualified in one specialty does not necessarily result in being qualified in another specialty.

1. Being a trained psychologist does not automatically make one a qualified user of all types of psychological tests;

2. Being qualified as a user of tests in a specialty such as personnel selection, remedial reading, vocational and educational counseling, or psychodiagnosis, does not necessarily result in being qualified in any other specialty involving the use of tests;

3. Being a psychiatrist, social worker, teacher, or school administrator, does not ipso facto make a qualified user of projective techniques, intelligence tests, standardized achievement tests or other tests or aids often used by members of these professions;

4. A trained psychologist's use of tests outside of his field of special competence should be solely for research or self-training purposes, with suitable precautions.

Principle III. - Ignorance on the part of a non-psychologically trained test user may be no breach of ethics on the user's part, but the release of a test to an ignorant user is a breach of ethics on the part of the test author, distributor, or other intermediary.

As an "intermediary" in the use of psychological tests, it is unethical for the agency to provide or purchase services, including evaluations, unless the person is qualified, is working at his level of competence, and uses only those tests and techniques in which he is skilled.

Most rehabilitation counselors should be capable of working with tests on Level B as defined above. Through his close personal experience in working with the physically handicapped many rehabilitation counselors are in a much better position to relate test data to the physically handicapped population than are other guidance workers or psychologists who are trained in the general use of tests but are not acquainted with their predictive powers as far as the handicapped population is concerned.

Content of a Psychological Evaluation

In addition to using psychological tests there are many things that the counselor can do to gather information towards the total psychological evaluation. These include the following:

1. Review of educational experiences. The counselor should secure as much information as he can in regard to the client's previous educational experience. Remembering that the best single indicator of what a student will do academically in the future is his previous grade point average, his high school and college grades should be obtained as well as any other information that the school has in regard to his rank in class and scores on psychological tests administered during the time he was in school. Information on his social adjustment to the school as well as his participation in athletics and other social events are of help.

2. Assessment and Personality. In addition to the use of paper and pencil or even projective personality tests the counselor should be able to gather information about the client by observing his behavior during the counseling interview and other contacts. He should evaluate the following variables; the client's reaction to his disability, his feelings in regard to adjusting to disability; the effect of the disability upon his social adjustment in the community; his attitude towards exposing himself to the physician for the general medical, specialist's report, and other medical examinations. It would also be well to observe any marked deviations in personal appearance and changes in behavior during the interview, as well as general impressions in regard to tension, hostility, passivity, etc. During the interview he should look for signs of excessive nervousness, such as rapid talking, blocking of speech, giggling, excessive

perspiration and overt anxiety and fear out of proportion to the situation. During the interview he should also be able to get some general ideas of the client's general ability level as far as verbal functioning is concerned. He should be able to evaluate his general ability in terms of his skill in expressing himself adequately and the amount of realistic thinking that is reflected in his current vocational planning.

The psychological evaluation is in no way an isolated process but involves all of the variables mentioned above. The job of the rehabilitation counselor is to understand and to integrate all of the information that he gained during the psychological evaluation into a reasonable vocational plan and to provide psychological services that will allow the final objective to be reached. In addition to the use which can be made of tests for diagnosis and prediction they can also provide valuable information for ongoing research within the agency itself.

Counselor's Use of Tests

The amount of psychological testing that an individual counselor will perform will depend upon several factors: his training and experience; the amount of time he has available for testing; and, the policy of the agency that employs him. As mentioned in a previous section of this manual the training and work experience of rehabilitation counselors who are now employed by State and private rehabilitation agencies varies greatly from State to State. In many States nearly every counselor on the staff would be qualified to use tests as outlined above while in other States very few counselors would have sufficient training either to administer or score psychological tests.

The policy of the agency also varies in the extreme from State to State and often times within agencies of the same State. Some agencies expect their counselors to do nearly all the psychological testing that may be involved in any particular case, while other agencies feel that these services should be purchased in the same way that medical or any other necessary services are purchased. In the majority of States it would seem that the rehabilitation counselor is expected to be qualified to administer and evaluate tests in the areas of mental capacities, interests, and personality traits within the normal range.

The Committee on Psychological Testing at the First Annual Workshop of Supervisors of Guidance, Training and Placement held in 1947 emphasized this concept when they specified "a recommended minimum basic testing kit for each rehabilitation counselor." In regard to this kit, DiMichael (13) has the following to say: "the use of the counselor as a service resource for clients where the counseling testing kit is suitable has several advantages. The counselor is able to test a small group of clients at one time in such places as schools, outlying area offices, and other referral agencies. Some of the homebound may be served by the counselor on a scheduled visit. Some clients in far outlying areas may be tested without the difficulty of arranging travel and overnight lodging. We may also expect that more clients in need of psychological testing and evaluation will be provided the services."

While recognizing that the rehabilitation counselor in most states is certainly not trained at the doctoral level, and is not skilled in the use of tests as clinical diagnostic instruments, the fact remains that in the majority of cases the burden for the selection, use, and administration of psychological tests falls upon his shoulders. In many areas throughout the country psychological services are not available except in the larger cities and if a psychological evaluation is needed, it falls upon the shoulders of the rehabilitation counselor in the field to provide at least minimal services.

The counselor can make valuable use of test data during the counseling process, but there are several general techniques which should be observed. These are:

1. Develop short, clear, concise methods of describing to the client the purpose of the test he is taking and the meaning of the results - Get this out of the way before you go into the interpretation of his actual test scores - Then you can concentrate on his reactions of the test scores rather than run the risk of having to go back into a technical discussion of the purpose of the test, its construction, etc. during the interpretation period.

2. Make the test data meaningful in terms of the client's behavior. Make the transfer from the technical meaning of the test score to the client's past and present behavior. In using test scores ask yourself the following question: "What does the score mean in terms of this client's individual behavior?" and "How can I express the score to him in such a way that he can relate it to his past, present and anticipated future behavior?"

3. Do not become over identified with the client's test scores. The test scores are his, not yours. Present a test score in such a way that he can question it, discuss it, reject it, accept it, or modify it, without having to accept or reject you by doing so.

4. Know how you perform yourself on objective tests, and work out as best you can, a reasonable acceptance of your own test scores. Generally this will mean that you were able to work with test scores and interpret them objectively to the rehabilitation clients with whom you are working. If you think that test scores are either "very good" or "no good" you will be communicating this in many ways to the clients that you are working with. Avoid projecting your own subjective feelings into the objective tests that you are using.

5. Make sure that the interpretations you make to the client are based upon the meaning of his behavior as an individual with a handicap and not necessarily on the basis of the meaning of the test score as it was originally standardized on a non-handicapped population.

SUMMARY

Psychological testing may not be needed in all cases, however psychological evaluation is certainly involved in the planning of every rehabilitation program. In the rehabilitation process the counselor is responsible for orienting the client to the purpose of tests and providing an accurate interpretation of test results during the counseling process. The effective use of tests by the counselor is dependent upon the adequacy and the thoroughness of his training in this field. The counselor should be aware of his professional competencies in the area of evaluating a client's behavior and abide by the code of ethics proposed by the American Psychological Association, which is enclosed within this section of the manual. For a complete writeup on psychological services in vocational rehabilitation refer to the manual by DiMichael. Many of the specific topics touched on here are reported in detail in DiMichael's manual and should answer most of the questions which rehabilitation counselors can raise in regard to psychological services.

References and Suggested Readings

1. American Psychological Association. Technical Recommendations for for Psychological Tests and Diagnostic Techniques. Washington, D. C. The Association, 1954.

2. American Psychological Association Committee on Ethical Standards of Psychology - Section 1, "Ethical Standards and Public Responsibility." American Psychologist, November 1951 v. 6, p. 637.

3. Anastasi, Anne. Psychological Testing. New York: MacMillan, 1954.

4. Bixler, R. H., and Bixler, Virginia H., "Test Interpretation in Vocational Counseling." Educ. Psychol. Measmt., 1946, 6:145-155.

5. Bordin, E. S., "Four Uses of Psychological Tests in Counseling." Educ. Psychol. Measmt., 1946, 6: 361-373.

7. Buros, O. K. (Ed.) Fourth Mental Measurement Yearbook. Highland Park, N. J.: Gryphon Press, 1953.

8. Buros, O. K. (Ed.) Fifth Mental Measurement Yearbook. Highland Park, N. J.: Gryphon Press, 1959.

9. Cronbach, L. J.,"Assessment of Individual Differences." American Rev. Psychol., 1956, 7: 173-196.

10. Cronbach, L. J., Assessment of Psychological Testing. New York: Harper, 1949.

11. Dahlstrom, W. G., "Research in Clinical Psychology: 1954." J. Clin. Psychology, 1955, 11: 261-266.

12. Darley, J. & Hogenah, Wedo, Vocational Interest Measurement. Minneapolis, Minn.: University of Minn. Press, 1955. 279 pp.

13. DiMichael, S. G., Psychological Services in Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, 1959.

14. Dressel, P. L. & Mattson, L. W., "The Effect of Client Participation in Test Interpretation." Educ. Psychol. Measmt., 1950, 10: 693-706.

15. Elkin, F., "Specialists Interpret the Case of Harold Halzer." J. Abnormal Soc. Psychol., 1947, 42: 99-111.

16. Fine, S. A., "A Structure of Worker Functions." Personnel Guid. J., 1955, 34: 66-74.

17. Fine, S. A., "USES Occupational Classification and Minnesota Occupational Rating Scales." J. Counseling Psychol., 1957, 4: 218-223.

18. Fine, S. A. and Heinz, C. A., "The Estimates of Worker Trait Requirements for 4,000 Jobs." Personnel Guid. J., 1957, 36: 168-174.

19. Fine, S. A. and Heinz, C. A., "The Functional Occupational Classification Structure." Personnel Guid. J., 1958, 37: 180-192.

20. Forer, B., "The Fallacy of Personal Validation: a Classroom Demonstration of Gullibility." J. Abnormal Soc. Psychol., 1949, 44: 118-123.

21. Garrett,H. E., Statistics in Psychology and Education. (Rev. Ed.) New York: Longmans-Green and Co., 1958, 478 pp.

22. Garrett, J. F. (Ed.) Psychological Aspects of Physical Disability. Office of Vocational Rehabilitation, Washington, D. C, 1953.

23. Gustad, J. W., "The Evaluation Interview in Vocational Counseling." Personnel and Guid. J., 1957, 36: 242-250.

24. Hamilton, K. W., Counseling the Handicapped in the Rehabilitation Process. Ronald, New York, 1950.

25. Kelly, E. L. and Fiske, D. W., The Prediction of Performance in Clinical Psychology. Ann Arbor: University of Michigan Press, 1951.

26. Kelly, E. L., "Theory and Technique of Assessment." Ann, Rev. Psychol., 1954, 5: 281-310.

27. Lofquist, L. H., Vocational Counseling with the Physically Handicapped. Appleton-Century-Crofts, New York: 1957.

28. Otterness, W. B., Patterson, C. H., Johnson, R. H., and Peterson, L. P., "Trade School Norms for Some Commonly Used Tests." J. Appl. Psychology, 1956, 40: 57-60.

29. Patterson, C. H., Counseling the Emotionally Disturbed. New York: Harper, 1958.

30. Patterson, C. H., Counseling and Psycholotherapy: Theory and Practice. Harper, New York: 1959.

31. Patterson, C. H., "Predicting Success in Trade and Vocational School Courses: Review of the Literature." Educ, Psychol, Measmt., 1956, 16: 352-400.

32. Rothney, J. W. M., "Interpreting Test Scores to Counselors." Occupations, 1952, 30: 320-322.

33. Seeman, J., "A Study of Client Self-Selection of Tests in Vocational Counseling." Educ. Psychol, Measmt. 1948, 8: 327-346.

34. Soskin, W. F., "Frames of Reference in Personality Assessment." J. Clin, Psychol., 1954, 10: 107-114.

35. Strong, E. K., Vocational Interests Eighteen Years After College. Minneapolis: University of Minnesota, 1955.

36. Strong, E. K., Vocational Interests of Men and Women. Stanford University Press, Palo Alto, California, 1943, 746 pp.

37. Studdiford, W. S., "A Functional System of Occupational Classification." Occupations, 1951, 30: 37-42.

38. Super, D. E., Appraising Vocational Fitness by Means of Psychological Tests. New York: Harper, 1949.

39. Super, D. E., "Testing and Using Test Results in Counseling." Occupations, 1950, 29: 95-97.

40. Super, D. E., "The Preliminary Appraisal in Vocational Counseling." Personnel and Guidance J., 1957, 36: 154-161.

41. Tyler, Leona, The Work of the Counselor. New York: Appleton-Century-Crofts, 1953.

42. U. S. Department of Labor, Bureau of Employment Security. Estimates of Work Trait Requirements for 4,000 Jobs as Defined in the Dictionary of Occupational Titles. Washington, D. C.: U. S. Government Printing Office, 1956.

43. U. S. Office of Vocational Rehabilitation, Department of Health, Education and Welfare. Seventh Annual Workshop in Guidance, Training, and Placement. Report of Proceedings. Part I. Washington, D. C.: 1954. Mimeographed.

44. University of Arkansas, College of Education, Department of Vocational Teacher Education, and the Arkansas Vocational Rehabilitation Agency. Psychological Evaluation in the Vocational Rehabilitation Process. Fayetteville, Arkansas: 1957.

45. Use of Multifactor Tests in Guidance. American Personnel and Guidance Association. Washington, D. C.: A Reprint Series from Personnel & Guidance J.

46. Wyatt, F.,"Climate of Opinion and Methods of Adjustment." American Psychologist, 1956, 10: 537-542.

The understanding of a client's disability requires complete and carefully selected information concerning the disability and the client's response to this and other life experiences. Social evaluation is the securing of social history material which taken as a whole brings the client into focus as an individual distinct from others and points up his potential for benefiting from the rehabilitation process. Social history is necessary for a diagnosis of the total problem and is the background against which planning and treatment are predicted.

Some Characteristics of Social Evaluation

Information is secured in relation to what appears to be the problem(s) with which the client needs help and the help which the agency is prepared to give. Some of the content included in the history may be contained in the routine "survey." However, this should be supplemented in narrative recording as other problems are identified or as additional information is obtained. The history should not be cluttered with irrelevant information. The primary informant is the client. If the agency is a member of a local Social Service Exchange a record is available of the social agencies to which the client is or has been known. Reports from these agencies should be obtained and significant material incorporated under the appropriate headings in the psychosocial history. With the client's permission, relatives, employers and school personnel may be interviewed.

Information not obtained from the client may be incorporated in appropriate sections of the history with the particular source identified. While encouraging the client to tell his own story in his own way, the counselor guides the interview, keeping in mind the areas in which information is desired. Note taking or recording should be kept to a minimum if an easy relaxed atmosphere is to be maintained. If the client gets the impression that the counselor is asking questions and then recording the answer, he will soon learn to wait for the next question.

The technique of history taking and writing is developed through practice. It is necessary for the counselor to hear as well as listen. He must bear in mind the importance of the sequence of events, associating the appearance of certain reactions with particular experiences. For example, was there any change in the health picture following divorce or trouble on the job? Reaction to disability is influenced by personality structure and cultural background. The type and extent of information needed varies according to the character and extent of the disability and the problems which emerge during discussion. The counselor should explain that in order to plan for successful rehabilitation he must know the client as a person; his health history; how and where he has lived; his education; his interests, etc. There is no set form or procedure for the taking of a history. For example, early life history may be discussed last depending upon the client's reactions, but

usually the major disability is a logical beginning point. If the counselor simply asks the client to tell about the trouble he is having, he will generally have little difficulty in getting a detailed description of the current disability.

Outline of Social History

The following are suggested items to be included for use in systematically recording this information.

Identifying Data - name, address, date and place of birth, citizenship, military service, names and addresses of parents, marital status, nationality, number and ages and sex of children, religion. List sources of information from which history is obtained.

Referral - source and reason.

Medical - social information.

Present Illness - History of present illness; date of injury or onset of illness; client's description of disability. What was client's personal situation at the time -- married, working, in school? How has it affected him? His family? What has he done about it? Has it increased in severity? What does he think could be done about it?

Previous Medical History - Identify and give dates of previous illness or injuries; client's account of disabling effects and treatment. Secure dates of previous hospitalizations and names of hospitals as well as names of physicians to whom client has previously been known. Counselor should secure the client's written permission for release of information from each of the medical sources. This information should be obtained as early as possible in order that it may be shared with the examining physician and medical consultant of the vocational rehabilitation agency.

Personal and Family History

Early Life and Cultural Climate of Home: The counselor should secure information regarding childhood and early family relationships. This may be approached by asking where client lived as a child. Such things as the parents' background, occupation of father, number of brothers and sisters, client's place in numerical order, early family relationships, etc., may be revealed quite naturally in discussing some of his early life experience and the information may then be organized under the proper heading when recorded.

Education: How far did the client go in school? How old was he when he left school? When did he complete grammar school? High school? How did the disability or previous illness affect his school progress? A record of school grades should be secured whenever possible. A report of psychological tests given at school and elsewhere may make an important contribution in completing an appropriate vocational plan. How does the client describe his social activities at school? Was he a member of clubs? Did he participate in athletic groups, etc.? While the psychological findings together with school progress may give evidence of intellectual capacity, it should be borne in mind that other factors such as physical and mental health, cultural influences and geographical location may also play an important part in educational achievement. Is client's educational attainment commensurate with that of other members of the family and community patterns?

Work History: What kinds of work has the client done and how long has he worked at these different jobs? What is his own estimation of how well he got along at work and of his relationships to his employers and fellow employees? What kind of work did he like best and what kinds did he find unsatisfactory? Does he express hostility in regard to some of his work experiences? Does he have a specific trade? Has he done skilled or unskilled work? How have local employment opportunities affected his work history? What ambitions does he express for the future?

Present Family Relationships and Economic Situations: Throughout the client's life the nature and quality of family relationships exert a strong influence on his reaction to each new experience. It is as important to understand as much as possible about these adult relationships as it is those which occurred during his early formative years. How close has he remained to his parents, brothers and sisters? The counselor will want to know many things about the client's current home situation including such things as what persons make up the immediate household, sources and adequacy of support, client's position in the home, and how the disability affects relations among family members. What are the standards of living of the family and what is their position in the community? Do members of the family share in social activities? Are there evidences of harmony or discord which might significantly affect the outcome of vocational rehabilitation efforts? Are members of his family willing to help him overcome the handicapping effects of his disability? If client is married, what is the attitude of his wife (husband) toward him at this time? Are client and wife (husband) living together? Were they ever separated? What are the evidences of strengths and weaknesses as they affect the client's potential for rehabilitation? If there are children in the family, how do parents and children get along together? What is known of the physical and mental condition of the children? What are client's ambitions for them?

Personality and Habits: Here the counselor attempts to gain some description of the client as a person prior to the onset of the disability as well as at present: His disposition, interests, reactions and personal habits. Does he show particular concern about his situation? What social activities does he take part in? Has he been a leader or a follower? What is his personal appearance and manner? Is there any evidence of a severe emotional problem? Describe behavior which indicates this.

NOTE: The questions listed above are only a few suggestions to be used in obtaining a detailed history and information necessary in making the social evaluation. The counselor will usually receive more helpful information from the examining physician, psychologist or social agency if pertinent and relevant personal and health history are shared in advance of the examination. The counselor may at the same time present questions for special consideration, the answers to which can be of help in subsequent vocational planning.

SUMMARY

It was pointed out in this section that the social study should present the client within the framework of his social reality, which presents not only his strengths and weaknesses, but also individualizes the meaning of his disability to himself and his family. The social study should reveal the circumstances around which the handicap or disability occurred, and its particular meaning at the time to the client and his family. The social study of the total family structure is an important tool in all phases of helping a person to rehabilitate himself.

Some of the characteristics of social evaluation were identified, such as: collection of pertinent identifying data, referral source, present illness, previous medical history, early life, education, work history, present family relationships, economic situation, personality and habits. This social information, when taken as a whole, should bring the client into focus as an individual distinct from others. It should point up his potential, for benefiting from the rehabilitation process.

The correct social evaluation is vital to the counselor's professional helping relationship to the client, his family and also to other members of the rehabilitation team. There is no set procedure for taking the social history, although the major disability may be a logical beginning point. It is necessary for the counselor to both hear and listen. When this is done, he will have little difficulty in getting a detailed description of the current problems of the client.

A suggested outline for social evaluation was included for study by the counselor. The rehabilitation counselor will usually receive more helpful information from physicians, psychologists and social workers, if pertinent and relevant personal and health history are shared in advance of the examinations. In this way the other members of

the rehabilitation team have some guide posts in terms of their own individual efforts on behalf of the client. As Elledge (5) has aptly stated, "the better we understand people within their social reality, the less likelihood there will be of uncooperative cases."

References and Suggested Readings

1. Clough, G. Sr., "Teamwork in Rehabilitation." American Arch. Rehabilitation Therapy, March 1956.

2. Dimchevsky, Esther M., "The Social Content of Work with Crippled Children." Mental Hygiene. July 1939. 23: 2: 421-431.

3. Elledge, Caroline H., "Medical Social Worker" H. A. Pattison (Ed.) The Handicapped and Their Rehabilitation. Springfield, Thomas 1957, 414-426.

4. Elledge, Caroline H., "The Meaning of Illness." Medical Social Work. April 1955.

5. Elledge, Caroline H., The Rehabilitation of the Patient; Social Casework in Medicine. Philadelphia: J. B. Lippincott, 1948. 112 pp.

6. Erickson, C. E., The Counseling Interview. New York: Prentice-Hall, 1950.

7. Hamilton, G., Psychotherapy in Child Guidance. New York: Columbia University Press, 1947.

8. Jones, M., Rehabilitation in Psychiatry. United Nations. World Health Organization, July 1952.

9. Mead, S.,"Some Reflections on the Rehabilitative Process." Kaiser Foundation M. Bull. 3: September-October 1955.

10. Perlman, Helen, Social Casework. The University of Chicago Press, 1957.

11. Report of the Subcommittee on Paramedical Personnel in Rehabilitation and Care of the Chronically Ill. Washington, D. C.: Office of Defense Mobilization, January 1956.

12. Upham, Frances, A Dynamic Approach to Illness; A Social Work Guide. New York, Family Service Association of America, 1949. 200 pp.

13. Weymouth, Edna C.,"Medical Social Work; Aide to Adjustment." Crippled Child. February 1950, 27: 3: 14-15, 28.

The importance of vocational evaluation in the client study process cannot be over emphasized for it is here that all other information is united with specific vocational data in an attempt to arrive at the ultimate goal of the rehabilitation process -- vocational success. Vocational evaluation is the process of gathering, interpreting, analyzing, and synthesizing all the vocationally significant data that have been collected regarding an individual, and relating it to occupational requirements and opportunities.

In reviewing the vocational area the counselor seeks to acquire an understanding of the client's aptitudes, skill, work habits, attitudes, interests, goals and motivations. The counselor gives special attention to any previous attempts to find employment, as well as experience in work adjustment units or sheltered workshops following the onset of the disability.

The work history which is obtained includes the name, address, and kind of business of all employers, specific jobs held by the client, duration of each job, and wages earned. The emotional significance to the client of occupational successes and failures is evaluated. The nature of hobbies and part-time work is determined; special vocational assets such as union membership, ownership of a car, and/or an occupational license are noted, and names of acquaintances who can help him secure, or train for, employment are recorded.

The client's account of his work history can be augmented by reports from former employers or fellow employees. Interest inventories and aptitude tests may frequently be used to supplement information obtained from other sources.

Examples of vocational problems which the counselor may assist in solving are: (1) Insufficient understanding of capacities and interests, (2) lack of occupational information, (3) selection of job objectives in line with abilities and interests, (4) choice of and arrangement for course of training, and (5) location of and adjustment to a job.

Development of Vocational Choice

As stated previously, in order to assist the client in arriving at a suitable vocational choice, an appraisal should have been made of the individual and of his environment. All pertinent medical, psychological, and personal-social data are now summarized and evaluated in light of the individual's aptitudes, skills, interests, and personality traits. The client's environment situation and job opportunities in his community or practical area of mobility are equally important.

When the client through counseling comes to understand his interests, aptitudes, and personality traits and how they can best be utilized in the world of work, he can then derive optimal benefit from

occupational information. Occupational information should include job duties, salary level, work requirements, advantages and disadvantages of the occupation, the employment outlook in suitable work areas and employment trends in general. Much information is contained in publications which the counselor can make available to the client. (See bibliography)

The client is encouraged to seek information on job duties and work requirements from such sources as the Dictionary of Occupational Titles, Occupational Outlook Handbook, Occupational Abstracts, etc. The client should evaluate the advantages and disadvantages of occupations under consideration, and he may be referred to carefully chosen successful workers. Additional information may be secured from the publications of the State Employment Service, from libraries, and other sources. Occupational information given the client covers jobs which are indicated as suitable by the vocational evaluation. The client is encouraged to use occupational information to help him narrow his choice of occupations under consideration.

The final employment objective is usually stated in terms of an organized classification of jobs, such as that presented in Part IV of the Dictionary of Occupational Titles. As a general rule the objective should be no more specialized than is indicated by the four digit code.

The selection of the objective is made prior to the actual provision of rehabilitation services; however, it cannot be considered apart from the service to be provided. The preparation needed for entry into the occupation should be attainable with the scope of the resources available to the client.

The development of a suitable employment objective is a joint undertaking of the counselor and client, and the client's participation should be evident in all phases. The most obvious example of this participation is in the gathering of data whereby the client is called upon by the counselor to relate his vocational history, interests, and abilities as he sees them. As his interests and abilities change or become clearer to him, he is encouraged to verbalize these perceptions. The counselor may make the appointment for the client to visit the various schools, shops, factories, etc., in which he expresses an interest; however, the utilization of these experiences is primarily the responsibility of the client. The counselor interprets the test results, but the client's acceptance and integration of the results are the more meaningful activities.

The counselor should recognize that in a free democratic society the final choice is made by the client. The counselor attempts to protect this right by skillfully assisting the client to the proper degree of self understanding.

SUMMARY

The counselor helps the client through counseling to use medical, psychological, and social data to form a realistic appraisal of his present capacities, his personal characteristics, and his job potentialities; to obtain information on job requirements and opportunities; and on the basis of such information and understanding to select a job objective and to carry through a vocational plan that will lead to his vocational rehabilitation. This choice of one's life work is a decision in which a client is called upon to state rather definitely his self-concept, to say, "I am willing to be this kind of a person." Similarly, holding and adjusting to a job is for the client a process of determining whether that job lets him play the kind of role he wants to play, and whether the role the job forces him to portray is compatible with his self-concept. Finally, work provides an opportunity for the client to test his self-concept with reality; a chance to determine whether he can measure up to his perception of himself. The job must be acceptable to the client's self-concept if the entire rehabilitation process is to succeed.

References and Suggested Readings

I. Basic Text Books

1. Baer, M. F. and Roeber, E. D., Occupational Information, Its Nature and Its Use. Science Research Associates, Chicago: 1951, pp. 592.

2. Caplow, Theodore, The Sociology of Work. University of Minnesota Press, Minneapolis, Minnesota, 1954, pp. 330.

3. Darley, J. G. and Hagenah, Theda, Vocational Interest Measurement, Minneapolis, University of Minnesota Press, 1955.

4. Forrester, Gertrude, Occupational Literature, H. W. Wilson Company, New York: 1954.

5. Ginzberg and Associates, Occupational Choice, Columbia University Press, New York: 1951, pp. 253.

6. Greenleaf, Walter J., Occupations and Careers, McGraw-Hill Book Company, Inc., New York, 1955.

7. Hollingshead, A. B., Elmtown's Youth, 1949, John Wiley & Sons, Inc., New York.

8. Hoppock, Robert, Occupational Information, McGraw-Hill Book Company, Inc., New York: 1957, pp. 523.

9. Roe, Anne, The Psychology of Occupations, John Wiley & Sons, Inc. New York: 1956, pp. 139.

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10. Shartle, C. L., Occupational Information, Its Development and Application. Prentice Hall, New York: 1959.

11. Strong, E. K., Vocational Interest of Men and Women, Stanford University Press, 1943.

12. Super, D. E., et al., Vocational Development A Framework of Research, Bureau of Publications, Columbia University, New York.

13. Super, D. E., The Dynamics of Vocational Adjustment, Harper, New York: 1942.

14. Super, D. E., The Psychology of Careers, Harper Brothers, 1957, pp. 346.

15. Thomas, Lawrence G., The Occupation Structure and Education. Prentice Hall, Inc., Englewood Cliffs, New Jersey, 1956, pp. 502.

16. Williamson, E. G., Students and Occupations. 1937, Henry Holt and Company, Inc., New York.

II. Journals Featuring Articles on Occupational Information

1. Educational and Psychological Measurements, (Editor: G. Frederic Kuder), Duke University, College Station, Durham, North Carolina.

2. Journal of Applied Psychology, (Editor: John G. Darley), University of Minnesota, published by the American Psychological Association.

3. Journal of Educational Psychology, (Editor: R. G. Kuhlen), Syracuse University, published by the American Psychological Association.

4. Personnel Psychology, (Editor: Erwin K. Taylor), Western Reserve University, Cleveland, Ohio.

5. The Personnel and Guidance Journal, (Editor: Joseph Samler), Veterans Administration, published by the American Personnel and Guidance Association (formerly Occupations).

III. Scholarships and Financial Aid

1. Adams, George, How to Afford Client College Education and Where to Study, Harian Publications, 1952, pp. 250.

2. Federal Scholarship and Fellowship Programs and Other Government Aids to Students. Washington, D. C.: Legislative Reference Service, Library of Congress, 1950.

3. Fellowships and Other Aids for Advanced Work, Mary M. Pendergrast, New London, Connecticut, published by The Institute of Womens Professional Relations, 1947.

4. Financial Aid for Students, Purdue University, 1953, 32 pp.

5. Financing Your Way Through College, B'nai B'rith Vocational Service Bureau, 1952, 8 pp.

6. Jewish Vocational Service Guide to Scholarship in the Chicago Area, Jewish Vocational Series, 1952, 6 pp.

7. Jones, Theodore, Your Opportunity to Help Yourself to Help Others, 1952, 222 pp.

8. Plaut, Richard T., Opportunities in Inter-Racial Colleges, National Scholarship Service and Fund for Negro Students, 1951, 240 pp.

9. Scholarships, Fellowships and Loans, S. Norman Feingold, Boston: Bellman Publishing Co., 1949.

10. Study Abroad: International Handbook of Fellowships, Scholarships and Educational Exchange, UNESCO, Columbia University Press 1949.

11. Wilkins, T. B., Scholarships and Fellowships, U. S. Department of Health, Education, and Welfare, Office of Education, Government Printing Office, 1954, pp. 248.

IV. College Information

1. Brownstein, Samuel C., College Bound, Barron's Educational Series, Inc., Great Neck, New York, 1957.

2. Bennett, Margaret E., College and Life, McGraw-Hill Book Company, New York, 1955.

3. Bogue, Jesse P., (Ed.) American Junior Colleges, Fourth Edition, 1956, American Council on Education, Washington, D. C.

4. Fine, Benjamin, American College Counselor and Guide, Prentice-Hall, Inc., New York, 1955.

5. Fine, Benjamin, How to be Accepted by the College of Your Choice, Channel Press, Great Neck, New York, 1957.

6. Havemann, E., and West, Patricia, They Went to College, Harcourt and Brace, New York, 1952.

7. Hurt, H. E., and Abbot, Merion E., College Blue Book, Yonkers, New York, Christian E. Burckel, 1956.

8. Irwin, Mary (Ed.), American Universities and Colleges, Seventh Edition, 1956, American Council on Education, Washington, D. C.

9. Shosteck, Robert, The College Finder, Washington, D. C., B'nai B'rith Vocational Services Bureau, Washington, D. C., 1955.

10. Zapoleon, Marguerite, The College Girl Looks Ahead, Harper and Brothers, New York, 1956.

V. Significant Recent Publications (Miscellaneous)

1. A Policy for Skilled Manpower, National Manpower Council, New York, Columbia University Press, 1954.

2. Estimates of Worker Trait Requirements for 4,000 Jobs, U. S. Department of Labor, Superintendent of Documents, U. S. Government Printing Office, Washington, D. C.

3. Improving the Work Skills of the Nation, National Manpower Council, New York, Columbia University Press, 1955.

4. Occupational Outlook Handbook, 1959 Edition, U. S. Department of Labor, Superintendent of Documents, U. S. Government Printing Office, Washington, D. C.

5. Standard Industrial Classification Manual, Executive Office of the President, Bureau of the Budget, U. S. Government Printing Office, Washington, D. C.

6. Womanpower, National Manpower Council, New York, Columbia University Press, 1957.

7. Statistical Abstract of the United States, 1956, U. S. Department of Commerce, Bureau of The Census, U. S. Government Printing Office, Washington, D. C.

VI. Information Related Specifically to the Handicapped and Disabled

1. Blind Worker In U. S. Industries, National Society for the Blind, 1943, 170 pp.

2. Bridges, Clark D., Job Placement of the Physically Handicapped, New York, McGraw-Hill Book Company, 1946.

3. Counselors' Guide - How to Find Employment and Place Blind Persons on Jobs of an Industrial Character in Non-Industrial Areas, 1953, Department of Health, Education and Welfare, Washington, D. C.

4. The Disabled in Hospital Employment, Loren T. Rice, M. S., Rehabilitation Service Series No. 275, 1954, Department of Health, Education, and Welfare, Washington, D. C.

5. Employment of the Physically Handicapped, A Bibliography, President's Committee on Employment of the Physically Handicapped, Superintendent of Documents, Washington, D. C.

6. The Handicapped Man for the Job; The Job for the Handicapped Man, National Association of Mutual Casualty Companies, New York.

7. The Handicapped in Defense, Employment of Physically Handicapped Persons at Hill Air Force Base, 1952, Utah.

8. Neuschutz, Louise M., Jobs for the Physically Handicapped, Beechhurst Publishing Company, 1944, 240 pp.

9. Occupational Information in the Vocational Rehabilitation Process, College of Education, University of Arkansas, Fayetteville, Arkansas, 1958.

10. Occupations of Totally Blind Veterans of World War II and Korea, Pamphlet 7-10, Department of Veterans Benefits, Veterans Administration, Washington, D. C.

11. Operations Manual for Placement of the Physically Handicapped, U. S. Civil Service Commission, U. S. Government Printing Office, Washington, D. C.

12. Opportunities for the Deaf and the Hard of Hearing Through Vocational Rehabilitation, U. S. Office of Vocational Rehabilitation, 1951, 24 pp.

13. Selective Placement of the Handicapped, International Society for the Welfare of Cripples, New York 1957.

14. Selective Placement for the Handicapped, U. S. Department of Labor, Employment Service, Government Printing Office, Washington, D. C. 1945.

15. Self-Employment, Department of Health, Education, and Welfare, Washington, D. C.

16. Small Business Enterprises for the Severely Handicapped, Government Printing Office, Washington 25, D. C., 1955.

This section of the manual contains three different rehabilitation case abstracts. This material was included in the training manual for teaching purposes. It is designed to provide an immediate opportunity for the practical application of the material presented in the preceding section.

The general format for each of the abstracts is basically the same. Information about the case is presented followed by discussion questions related to the total client-study process.

Client-Study Case Abstract No. 1
The Case of Mrs. P.

Referral Source

Mrs. P. was a self referral. The vocational rehabilitation counselor met her while investigating her husband who had been referred by a county welfare office. She had previously lost a job as a maid in a hotel and was in danger of losing a part-time job as a presser in a laundry. She complained of pain in her feet and legs, low abdominal pain, pain in the pelvic region, severe nose bleeds, and made some vague reference to "female trouble."

Social Data

Mrs. Jane P. is a 19 year old female. She comes from a very limited rural socio-economic background. She and her husband have been married less than a year and have no children. They live in a poorly furnished one room apartment. Mr. P. is 20 years old and suffers from chronic asthma. At present he is unemployed. They had been drawing general relief in White County before moving to this locality. They are not receiving any public or private assistance at the present time, although Mrs. P.'s wages have not been sufficient to provide adequately for them.

Mrs. P. presents a pleasant general appearance. She dresses neatly, but her choice of clothes clearly reflects her limited socio-economic background. Although she likes her work and needs to hold her present job, she states she would prefer being a housewife if circumstances would permit. Nevertheless, she has apparently accepted the necessity of providing for herself and her husband. She seems to have good judgment and responds to questions thoughtfully and without too much defensiveness or exaggeration. She says she thinks she would be happier working with a group. From the reference given it appears that her circle of acquaintances is limited.

Discussion Questions

1. How important is Mrs. P.'s history with the public welfare agency? How can such data be obtained? Should the client's permission be secured and if so, how?

2. What is the possible relationship between the limited socio-economic background from which she comes and her probable level of aspiration in establishing a vocational objective?

3. Is Mrs. P.'s role as provider for her husband a factor in the determination of eligibility?

4. What efforts should be made to rehabilitate Mr. P. who is only 20 years of age? Should the major rehabilitation effort be directed toward Mr. P. before completing the investigation of his wife's case?

Educational History

Mrs. P. completed 11½ years of school, said that she liked school and was considered to be "good" student. She stated that the reason she failed to graduate from high school was due to the condition of her feet. She had to walk two miles to catch the school bus, and halfway through the senior year her feet became so painful she could not continue walking that distance. A transcript of her high school grades supported her report of being a "good" student, though not an outstanding one.

School authorities were not contacted about arranging for Mrs. P. to finish high school since it was believed that her disability would be reduced with medical care so as to obviate any need for training.

Discussion Questions

1. Was the counselor justified in not contacting the local high school because, "It was believed that her disability would be reduced with medical care so as to obviate any need for training?"

2. If the counselor had some doubt about the client's reason for quitting high school, how should he have gathered data in this area? Should the high school be contacted routinely in all cases? What permission, if any, is required?

Medical History

Mrs. P. stated that she had been in good general health except for her feet which had always been troublesome. The condition of her feet became so serious in her senior year of high school that they were the reason for her dropping out. She also said that recently she had been bothered with nose bleeds whenever she engaged in strenuous work.

Mrs. P. was sent to a local physician for her general medical examination. On the basis of this report she was also referred to specialists in the areas of orthopedics and eye, ear, nose, and throat.

Discussion Questions

1. What ethical questions are involved in the selection of the physician who is to give the general medical examination?

2. If the client has no regular family physician, on what basis should a physician be selected?

3. When the general medical report indicates the need for a specialist examination, should it be secured before or after discussing or reviewing the case with the vocational rehabilitation medical consultant? How are the correct fees for the general medical and specialist examinations established?

4. Should the medical reports be mailed directly to the counselor or to the vocational rehabilitation medical consultant? Should the counselor contact examining physicians personally, or is it best to have the vocational rehabilitation medical consultant do so?

General Medical Examination Record

This record is confidential

P.	Jane	F	Age 19	Sex F	M S W D
(Last name)	(First)	(Middle)			

Section I (To be filled out by Rehabilitation Agency)

Omitted

Section II Physical Examination (To be filled out by physician)

Height	5 feet 5 3/4 inches	Weight	139 pounds
Eyes:	Right: Normal, 20/20	Left:	Normal, 20/20
Ears--	Hearing: Right 20	Left	20
	Drum scarred		Drum scarred, old infection (none now)
Nose	Nasal congestion, recent hemorrhage from septum		
Mouth	3rd molar and 2nd molar lower right		
Throat	Chronic infection and hypertrophy		
Neck	Normal thyroid, no lymphadenopathy		
Lungs:	Right no evidence of disease	Left	no evidence of disease
Circulatory System:	Heart Normal	Blood Pressure	120/72
	Pulse Rate 76	Dyspnea none	Cyancsis none
Edema	None	Evidence of Arteriosclerosis	None
Abdomen	Normal	Hernia	None

Genito-Urinary and Gynecological Tender right adnexa
Ano-Rectal Normal
Nervous System Normal individual
Skin Clear, Normal
Feet Pes Planus bilateral Varicose veins Early varicosities, both thighs
Orthopedic Impairments 1. Early varicose veins
2. pes planus bilateral

Laboratory: Blood Serologic Test

Date	7-1-59	Date	7-1-59	Sugar	none
Test	VDRL	Sp. Gr.	1022	Micro	neg.
Result	Negative	Reac.	Ac.	Albumen	none

Disabilities: Major EENT Complaints
Minor Pes Planus

Both can be removed or substantially reduced by treatment.

Recommendations: Consultation with Orthopedist and E.E.N.T.

Treatment indicated E.E.N.T.

Types of activity to be avoided: Long standing, heavy lifting

Working conditions to be avoided: Long standing, heavy lifting

Your personal evaluation of this patient: Good health generally, but is in need of treatment of E.E.N.T. and for flat feet and varicosities.

/s/ Richard Doe, M. D.

7-1-59

Specialist's Report - Orthopedist

August 1, 1959

Re: P., Jane F.

Jane F. P. was examined in my office on the afternoon of August 1, 1959.

History: Mrs P. states that she has had trouble with her feet for several years and recently has had some back ache and cramping of the calf muscles. She is employed as a steam presser in a laundry which required her to stand on her feet for long periods of time.

Examination:

Back: The vertebrae are in good general alignment. Motion of the spine is not restricted. There is a mild degree of tenderness in the lumbosacral area of her spine, but no definite deformity exists.

Lower Extremities:

Hips: Motion is normal. No edema or tenderness.
Thighs: Well developed. No muscle atrophy. No areas of tenderness or impaired sensation. There are several superficial varicose veins, but they are not symptomatic.
Knees: Motion is normal. No edema or tenderness.
Legs: Well developed. No muscle atrophy. There is some soreness of the calf muscles on deep pressure, bilaterally.
Ankles: Motion is normal, bilaterally. No edema or tenderness.
Feet: There is marked pes planus, bilaterally with pronation, associated with considerable weakness on exercises.

Diagnosis: Weak feet, bilateral, severe, with marked pronation, symptomatic.

Comment: It is recommended that this lady be fitted with corrective shoes and combination longitudinal arch supports in order to give her feet the proper balance. I feel that her feet are responsible for the aching in her legs and the discomfort in the lower portion of her back. As soon as these are procured I would like to check her to see if adequate balance of her foot has been obtained.

/s/ John Doe, M. D.

Specialist Report - E.E.N.T.

July 29, 1959

Mrs. Jane F. P. was examined by me July 29, 1959. Her complaint at this time was frequent nose bleeds. Examination revealed a large ulcer of the nasal septum located in the left nares. Treatment was cauterization of the ulcer.

Diagnosis: Ulcer nasal septum.

Sincerely,

/s/ John Jones, M. D.

Discussion Questions

1. Is the medical information in this case adequate? If not, what additional information does the counselor need?

2. How can the counselor help prepare the client for the experience of wearing corrective shoes and arch supports?

3. What are some cues to which the counselor must be alert in evaluating the "gadget tolerance" of the client?

4. What distinction should be made between eligibility for vocational rehabilitation and provision of specific services; e.g., corrective shoes?

Psychological Data

Since data was not obtained in regard to Mrs. P.'s high school cumulative record, a battery of tests consisting of the Army General Classification Text, Wechsler-Bellevue Scale, Form I, Kuder Preference Record - Vocational and Minnesota Multiphasic Personality Inventory were administered by a local psychologist on a fee basis. The results are indicated below:

Ability

Army General Classification Test - Score 96, 42 percentile (general population)

Wechsler-Bellevue Scale - Verbal I.Q. 96, Performance I.Q. 107, Full Scale I.Q. 103.

Interest

Kuder Preference Record (Vocational)
High in Social Service (81 percentile)
Low in Literary (23 percentile), Musical (21 percentile), and Scientific (17 percentile).

Personality

Minnesota Multiphasic Personality Inventory - Elevated scores on the following scales:

Hypochondriasis	(Hs)	74 (T score)
Depression	(D)	66 (T score)
Hysteria	(Hy)	72 (T score)

Abstract from psychological report

"Mrs. P. is a person of average general ability. The fact that she was a 'good' student in school is understandable because she is highly motivated to achieve. Her grades were better than might be expected in terms of her average general ability. She is concerned with economic problems, and her high interest in social service is likely a result of that. She seems to be accepting the necessary facts of her position, but no doubt would rather be in the role of a housewife rather than that of a provider.

"Her MMPI Profile would indicate that she is quite concerned with her physical condition and has a good deal

of anxiety. At the same time, however, her eagerness to work causes her to overlook her handicap as much as she can. At times she seems rather nervous and upset, which would be supported by her elevation on the Hs and Hy scales, accompanied by a slight declination of the D scale of the MMPI. This particular configuration is usually interpreted as indicating neurotic tendencies with a high level of anxiety as the salient feature. Her pressure pattern is probably the result of severe environmental stress. She is trying to deal with the pressure, but the maintenance of elevated Hs, Hy, and D scales show her attempts to be unsuccessful. In the absence of this type of environmental stress, she would probably make a normal adjustment."

Discussion Questions

1. Was the need for this detailed psychological evaluation clearly indicated in this case?

2. Were the services provided by the psychologist within the area that the typical rehabilitation counselor could reasonably be expected to provide?

3. How should psychologists used by vocational rehabilitation counselors be selected and how should their fees be determined?

4. What would you include in referral information to the psychological examiner?

5. How would you prepare the client for referral?

6. What information would you expect in the report of the psychologist? How would you use such information?

Vocational History

Mrs. P.'s principal employment has been as a domestic maid. While going to school she held part-time jobs of this nature in order to buy clothes for herself. A neighbor reported that she should be commended for being "capable, cooperative, and not afraid of work."

The job Mrs. P. had just prior to her present one was as a maid in a local hotel. This employment was terminated because of her physical inability to do the work.

Her present employer at the Jones Laundry, where she is working part-time, reported her to be punctual, able to get along well with other workers, and consistently producing very acceptable work. He stated that he would be willing to hire her full-time if her physical condition was such that she could stand the work.

Discussion Questions

1. Should the counselor accept the client's past employment as the optimum level of which she is capable of performing?

2. Who is responsible for determining Mrs. P.'s potential for performing full-time as a steam presser after services are provided? Who is in the best position to evaluate this?

3. Will the provision of physical restoration services enabling this client to work full-time at her present job fulfill the counselor's responsibility to this client?

4. In your opinion is the vocational evaluation of this client complete?

Eligibility

Mrs. P.'s disability has been diagnosed as weak feet, bilateral, severe, with marked pronation, symtomatic. She also has a large ulcer of the nasal septum and several superficial varicose veins which are asymtomatic. The orthopedic specialist feels that the condition of her feet is responsible for the aching in her legs and the discomfort in the lower portion of her back. These conditions cause a material inability to carry out the duties of her regular work as a steam presser, and were reported to be the reason for the termination of her previous work as a domestic maid.

Discussion Questions

1. What is the major disability in this case and who makes this determination?

2. Has the counselor fully explained how the client's physical disability results in a substantial vocational handicap? If you feel that the explanation is unsatisfactory, how would you change or add to it?

3. What are Mrs. P.'s functional limitations? If Mrs. P.'s functional limitations following physical restoration interfere with satisfactory job performance, what are the counselor's responsibilities?

Summary:

Mrs. P. verbalizes an acceptance of her physical condition and its effect upon her availability for work. She has repeatedly stated that she likes her present job and is eager to continue work if she is physically capable of doing so. She is willing to cooperate with all required physical restoration services.

Discussion Questions

1. Should the counselor have explored more thoroughly the possibility of training for Mrs. P. in order to prepare her for a higher level and better paying position?

2. What is your general evaluation of the way this case was handled?

Client-Study Case Abstract No. 2
The Case of Sue S.

Referral Source

Miss S. was referred to the vocational rehabilitation counselor by her high school principal following her graduation from high school. She was referred because of a speech impairment. Mr. B. the principal, stated that she was a good student and that she participated in school activities on a limited basis. She was referred for counseling and possible college training.

Social Data

Sue is an attractive 18 year old girl who dresses in the mode of the teenager. She wears her blond hair in a pony-tail. She is 5' 2", weighs 105 pounds, and has brown eyes.

She lives with her mother, father, and 14 year old brother in a modern brick home at the edge of a small midwest town. The home is furnished very attractively in good taste. The relationship between Sue and her brother appears to be wholesome. Mrs. S. reportedly overprotects her, according to school records. Mr. S., the purchasing agent of the local branch of a large mining company, appears to let his wife run the household. Both parents are high school graduates.

Discussion Questions

1. How would the parents' expectations and concept of Sue's ability and vocational goal influence rehabilitation planning?

2. How important is the parents' attitude toward Sue's disability? What are some of the possible dynamics underlying the mother's reported "overprotection" of Sue?

Educational History

Sue graduated from the local high school last month. Her performance in high school was very good. She had a grade average only slightly less than an "A" for all of her high school work. She ranked first in a graduating class of forty, but ranked in only the 55 percentile on the Ohio State Psychological Examination based on high school senior norms.

Discussion Questions

1. Is Sue's performance in high school consistent with her results on the Ohio State Psychological Exam? If not, how would you account for any discrepancies?

2. Of what significance is Sue's membership in high school clubs and the hobbies engaged in while in adolescence?

3. How important is the length of time Sue has pursued particular activities in evaluating her high school interests?

Medical History

A medical abstract received from State Crippled Children's Service reported that Sue had a speech impairment resulting from a congenital malformation of the oral cavity. Services had been provided by State Crippled Children's Service in the form of surgery, and the report stated that no further physical restoration was indicated. No mention was made of any recommendations for, or history of, speech therapy.

The high school speech teacher reported that she felt Sue's basic speech defect was only moderate, but that there was an additional decrease in performance when she had to talk with strangers. This cleared up as she became acquainted with a person, and after some familiarity with her speech patterns was gained she could be understood without difficulty.

Discussion Questions

1. Would the counselor be justified in accepting a written medical summary from Crippled Children's Service in lieu of the general medical examination?

2. What time limits should be set on the acceptance of a medical report -- how recent must it be?

3. From what profession, or professions, would you obtain an evaluation of Sue's speech impairment? How much would you expect to pay for a speech evaluation?

4. What are your criteria for determining when a speech impairment constitutes a vocational handicap?

5. If the specialist's report indicates that Sue's speech impairment can be substantially reduced within a reasonable period of time, what is the responsibility of the vocational rehabilitation counselor with respect to vocational training in the event that she rejects speech therapy?

Psychological Data

The psychological data in this case were obtained from two sources: Sue's records in the counselor's office at the local high school and the testing provided by the vocational rehabilitation counselor.

Tests Results

Ability:

Ohio State Psychological Examination -

55 percentile when compared with high school seniors

Interests:

Kuder Preference Record (Vocational) -

High: Social Service, Literary and Clerical
Low: Mechanical and Persuasive

Aptitude:

Minnesota Clerical

90 percentile when compared with employed clerical workers.

The vocational rehabilitation counselor reported that Sue seemed to be relatively well adjusted, but sensitive about her disability. There was some evidence of maternal overprotection.

Discussion Questions

1. On the basis of the apparent discrepancy between Sue's ranking first in her class in terms of grade point average and her measured scholastic ability, what are her chances of completing college successfully?

2. On the basis of the test data what tentative vocational objectives would the vocational rehabilitation counselor explore with the client?

3. Would you recommend training away from home if it necessitated payment of maintenance, but was available locally without this expenditure?

4. What use would the vocational rehabilitation counselor make of the test material in helping Sue arrive at a vocational choice?

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Vocational Data

Sue's first stated vocational interest was in social work. She later said that she felt talking would be required to such an extent that she would give up this ambition, although she maintained an interest in the field. Her second choice was to enter clerical work where she thought she would not deal directly with so many people, and where she felt she would be at no disadvantage. She said she believed that she could obtain a clerical job locally with some additional training.

Discussion Questions

1. How would you help Sue make a more complete vocational analysis?

2. What methods would you employ in encouraging her to use occupational and educational information?

3. Do you believe she would be satisfied doing routine clerical work? Why? Why not?

4. Suggest some suitable occupations for Sue on the basis of the data you have. What are the bases of your choices?

5. What is your general evaluation of this case?

Client-Study Case Abstract No. 3
The Case of Joe B.

Referral Source

Mr. B. was referred to vocational rehabilitation by the personnel manager of a large automobile company following a heart attack which he suffered while working as a millwright. The referral was made for purposes of counseling and job placement.

Social Data

Joe B., a 41 year old male, is married and has three children, ages, three, seven, and nine. He is 5' 10" and weighs 190 pounds. He is of rather stocky build, has a ruddy complexion, blue eyes, and dresses appropriately. He lives in a neat three bedroom cedar shake ranch style home in the suburbs. He reports going on hunting and fishing trips with his neighbors and occasionally taking in the ball game. His drinking is limited to an occasional beer.

The family seems to be a cohesive one. Joe speaks highly of his wife and is obviously proud of the children. The two oldest are doing very well in school. Joe had hoped to save enough money that the children could attend college if they so desired. He has taken out insurance policies on the two older children for this purpose. Mrs. B. has not worked out of the home since their marriage 12 years ago.

Discussion Questions

1. What additional social data would be helpful in working with Mr. B.?

2. What information can you get from the records of the personnel manager which would be of help in evaluating Mr. B.?

3. Should the family's overall financial situation be investigated? What possible ethical questions are involved in this area?

Educational History

Joe has completed the 11th grade in high school with grades slightly above average. He quit high school to go to work.

Discussion Questions

1. Of what value is a high school transcript for a man in this age bracket?

2. Should company records be evaluated to see if he has taken any on-the-job training during the years he has been employed as a millwright?

Medical History

A detailed abstract of Joe's medical history was obtained from the company physician. The company has a progressive health program providing for mandatory periodic medical examinations. The abstract from the director of the company's medical program states that Joe's present physical condition is that of Class II-C according to diagnostic criteria distributed by the American Heart Association. A functional classification of II refers to individuals with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. More than ordinary activity results in fatigue, palpitation, dyspnea or anginal pain. Those with a therapeutic classification of "C" are patients with heart disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.

Joe denies any serious health problems prior to becoming ill while at work three months ago. He has always been in good health and missed hardly a day of work in twenty years at the 8th Street Plant.

Discussion Questions

1. How adequate is a medical abstract? What additional medical evaluation would you desire?

2. If you decided to send Mr. B. to a specialist in internal medicine, what information would you provide him?

3. What is the counselor's role in the event that the medical opinion of the company physician and that of the examining specialist are in conflict?

4. What is the counselor's responsibility if the client enters and persists in employment which is contra-indicated by medical opinion?

5. If a cardiac work evaluation unit is available, what would you expect to receive in a report from it?

Psychological Data

The client feels his present inability to support his wife and three children keenly, and would like to resume work as soon as possible. Although his former employer has agreed to rehire him and place him on light assembly work, he has rejected such a plan. He thinks that this could not utilize his knowledge and skill, would result in loss of pay, and would be a reduction in status to that of a semi-skilled worker. He feels he might be able to qualify for a foreman's job, but there are no openings at the present time in the plant where he worked and it does not seem likely that any openings will develop there in the near future. He also feels that there is not much possibility of finding a job with a new employer because, "No one will hire a man in my condition."

Test Results

The following battery of tests was administered by the vocational rehabilitation counselor:

Ability:

Wechsler-Bellevue, Form I - Verbal Scale I.Q. 120, Performance Scale I.Q. 109, and Full Scale I.Q. 115.

Interests:

Kuder Preference Record (Vocational) -

High: Mechanical and Scientific
Low: Persuasive, Artistic and Clerical

Aptitude:

BennettMechanical, Form AA -

93 percentile compared with apprentice trainee norms.

Discussion Questions

1. Is Mr. B.'s general ability in line with the type of work he has been doing for the past twenty years? Does he have the ability to work as a supervisor?

2. What additional psychological tests would you like to have administered to Mr. B.? Why?

3. Would psychological tests give some clues as to why he rejected the company's offer to return to work at what he perceived to be a lower level job?

Vocational History

Joe worked two years in a food processing plant before starting his apprenticeship at age 19 to become a millwright. He has worked steadily since that time as a millwright for the same company. He has a good work record, has earned good wages, has been satisfied with his work, and taken pride in his skill.

He is reported to have been a very good millwright, but to have had no other significant experience and little idea of his abilities or vocational potential outside of this work.

Discussion Questions

1. Where can the counselor find a job analysis on a millwright?

2. Where can he find information about related jobs which will permit maximal transfer of skills?

3. What resources might be utilized by the client and counselor in assessing the labor market of related jobs?

4. In the event that it does not appear that Mr. B. can ever return to employment as a millwright, should the counselor seek to provide counseling services aimed at bringing about a change in the client's basic self concept? Should the counselor attempt to provide such services himself, or should a referral be made to a qualified psychologist?

5. How would you deal with Mr. B.'s statement, "No one will hire a man in my condition?"

6. Of what vocational psychological significance is the client's age at onset of disability?

7. What type of training, if any, do you think might be explored with this client?

8. What is your general evaluation of this case?

PART THREE

CLIENT SERVICES

BASIC PRINCIPLES FOR DETERMINING ELIGIBILITY

This Section is concerned with specific requirements as well as basic principles used in determining eligibility for individuals applying for vocational rehabilitation services. A thorough understanding of the client study material which has been presented in previous sections should permit the use of such material for accurate evaluation and sound planning. The counselor is now faced with the immediate problem of using all of the material that he has gathered to arrive at a decision as to whether or not any particular client is eligible for vocational rehabilitation services. He must select the most significant data that he has compiled from the interviews, examinations, and all other reports in order to determine eligibility.

In most cases, tentative hypotheses about the client's eligibility and the possibility of bringing about successful vocational rehabilitation are made quite early in the case study process. These tentative hypotheses are then checked and re-evaluated as additional data are accumulated. The final vocational rehabilitation diagnosis is based on the total case study and upon the availability of required services. As significant facts come out and the counselor integrates them into the total diagnosis, a picture of the client's assests and liabilities become evident. As a rule, the relationship of the client's strengths and weaknesses to the selected job objective and to the rehabilitation plan should be clearly indicated at this point in the rehabilitation process.

Eligibility

The counselor is required to show that all of the following conditions exist for each individual determined eligible for vocational rehabilitation:

1. the presence of a mental or physical disability and the resulting functional limitation or limitations in activities;

2. the existence of a substantial handicap to employment caused by the limitations resulting from such a disability; and

3. a reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a remunerative occupation.

Disability and Functional Limitations

The counselor must determine in each case the presence of a mental or physical disability which substantially limits the individual's capacity to perform activities which the non-disabled person ordinarily performs. As stated in the previous section on the Client Study - Medical, this determination is generally made on the basis of either a general or specialist medical report. The disability must be identified and the consequent functional limitations defined. Eligibility for vocational rehabilitation services is dependent upon the limitations

imposed upon the individual by the disability, not by the mere presence of the disability alone.

Medical information is essential for adequate identification of the disability and the resulting functional limitations. Reports of medical examinations which the counselor secures as a part of the diagnostic study constitute a practical basis for determining disability and functional limitations. Medical examinations are required as a part of the comprehensive diagnostic evaluation as a basis for formulating the individual plan of vocational rehabilitation. Basic information used in making these determinations must reflect the client's condition at the time of the eligibility determination.

Substantial Employment Handicap

In the determination of eligibility for vocational rehabilitation services the counselor must establish the existence of an employment handicap. It must be demonstrated that the client's need for vocational rehabilitation services is a result of the disability, rather than circumstances not specifically related to it. The counselor must show that the functional limitations resulting from the disability reduce employment opportunities.

An employment handicap exists when an impairment substantially interferes with opportunity for suitable employment, causes loss of employment, necessitates modification or change in employment, causes the individual to require special assistance in securing suitable employment or in performing job duties.

Determination of the extent of the client's employment handicap presumes counselor appraisal of previous education, training and work experience, and determination of how impairments have limited the client's opportunity to prepare for suitable employment. In other words, the justification of the existence of a substantial employment handicap must clearly show the extent of the handicap, and the specific ways in which the client's manipulative, sensory, ambulatory, mental, or other limitations restrict his ability to secure or retain normally available employment in keeping with his physical and mental abilities, educational background, vocational interests and experiences.

Expectation of Outcome of Vocational Rehabilitation Services

As a part of the eligibility determination for each client, the counselor must establish that there is a reasonable expectation that vocational rehabilitation services, when completed, will lead to the individual's employment. It must be determined by the counselor that there is a likelihood that through the services the agency can make available, the client's ability to engage in employment will be increased. This requires the counselor to evaluate and ascertain potential capacity of the individual for employment, taking into consideration what effect the agency's service may have in alleviating his employment handicap and thereby providing greater potential for employment. This requirement

is primarily evaluated on the probable effectiveness of the services that can be made available, rather than on a time element, extent of need for services, or nature or severity of impairment.

The counselor should establish procedures which will assure individual appraisals designed to meet the varying needs of applicants. The extent of the evaluation may vary greatly from one client to another, depending on the nature and severity of problems imposed by the handicap or other factors affecting the applicant's employment adjustment. The counselor may experience more hindrance in determining eligibility of severely disabled clients as he may have difficulty in visualizing the expectation of employment.

A remunerative occupation may be any type of employment activity in which the individual is engaged on a full-time or part-time basis and for which he receives payment in cash or in kind. It may be in the competitive labor market, sheltered employment, homework activity, family or farm work, homemaking, practice of a profession or self-employment. The amount of earning is not a controlling factor in determining the individual's likelihood of engaging in employment activity.

Certification of Eligibility

The counselor is required to include a statement in the case record for each handicapped individual accepted for vocational rehabilitation services certifying that he has met the basic eligibility requirements. This statement must be completed prior to or simultaneously with the acceptance of the client and must be dated and signed. (In case of ineligibility a statement is required, also.)

Certification of the applicant's eligibility does not imply that he will be provided with rehabilitation services beyond diagnosis and evaluation. There may be need for further diagnostic evaluation to determine specific services the individual requires or may benefit from in accomplishing his vocational rehabilitation.

SUMMARY

Establishing eligibility for vocational rehabilitation services requires a series of decisions which involve identifying the physical or mental impairment, defining functional limitations, explaining how they interfere with occupational performance, evaluating need for vocational rehabilitation services which will overcome or reduce these interferences, and predicting the probable outcome of the vocational rehabilitation services.

These decisions require appropriate information about the client's physical or mental conditions, personal and social adjustment and outlook, education and training, work history, functional limitations, employment prospects, and the availability of services necessary for his vocational rehabilitation.

References and Suggested Readings

1. Proceedings of the 7th Annual GTP Workshop,"Counseling and Placement - Eligibility," 1954, pp. 37-60, OVR Rehabilitation Services Series Number 273.

2. Proceedings of the 8th Annual GTP Workshop, "Counseling and Placement - Eligibility," 1955, pp. 49-72, OVR Rehabilitation Service Series Number 331.

3. OVR Manual, Chapter 16, Section 1, Requirements and Basic Principles for Determining Eligibility.

4. OVR Manual, Chapter 21, Section 1, Establishment of Economic Need.

PLANNING AND PROVISION OF SERVICES

The goal of vocational rehabilitation is the suitable placement of the vocationally handicapped client. In this Section it is assumed that a thorough client study has been completed. The client is now ready, with the continued assistance of the counselor, to carry out a plan of action leading to placement in a suitable position.

Activation of Plan

By the process of synthesizing the data covered in the client study sections -- medical, psychological, social and vocational--the client and counselor now plan the rehabilitation services needed to effect the client's preparation for, entrance into, and adjustment in employment. It should be noted that planning permeates the client study process and is often initiated by the client prior to contact with the counselor. However, the specific activities involved in making the necessary arrangements are shared insofar as possible.

All services needed by the client are incorporated into the rehabilitation plan. Sometimes the counselor may take advantage of financial support and/or services from outside resources, including the client and his family. This is of particular importance when providing services based upon economic need. Such contributions and services are integrated by the counselor into the overall plan of rehabilitation.

Utilization of Client's Resources

Evaluating the client's financial circumstances is an integral part of rehabilitation planning. Generally it serves two basic purposes: (1) as a basis for counseling and planning a program of rehabilitation services, and (2) to establish economic need for services conditioned on need.

Good rehabilitation practice requires knowledge of the client's total economic circumstances so that this understanding can be related to other case information in order to counsel and plan a program of rehabilitation commensurate with the individual's needs. Without knowledge of the socio-economic background of the client rehabilitation plans may break down. From this point of view, evaluation of the applicant's economic situation becomes a basic process in rehabilitation and is generally undertaken whether or not the rehabilitation plan is to include services based on need.

Financial considerations are thoroughly intertwined in the reality of modern living. The concept of vocational rehabilitation recognizes this reality. Vocational rehabilitation counseling should look upon and carry out determination of financial circumstances of clients in a way that contribute to their growth, assumption of responsibilities they are able to carry, and rehabilitation.

In vocational rehabilitation, certain services are provided without cost to the individual only to the extent that he is unable to pay. This provision is in accord with the philosophy that the individual in our society supplies his own basic needs insofar as he can and that public funds are used for certain expenses only when the individual has insufficient resources to meet their costs. The services conditioned on need are: physical restoration; maintenance; transportation (except for diagnosis); occupational licenses; books and training materials; tools, equipment, initial stocks and supplies; other goods and services. Some states also condition training on economic need.

When agency provision of services to an individual depends upon whether he is able to pay for them, standards for making this determination are essential. In public programs, it is necessary to recognize and respect the equality of individuals under the law. This does not mean that all persons must be treated identically. On the contrary, the concept of equitability recognizes that individual needs differ and that equitable treatment is afforded by use of objective ways of measuring those needs and of treating persons with similar needs similarly. Fairness to the individual, to the taxpayer, and to the staff member who makes the decision on an individual's ability to pay, all necessitate some objective standard by which to measure "financial need."

While vocational rehabilitation is a program of highly individualized services, some needs are common to all people (i.e., basic needs for the ordinary requirements of living such as food, clothing, shelter). It is possible and necessary to measure such needs as these by objective standards which are applied to give all clients who are in similar circumstances like treatment. They cannot be measured equitably without such a standard. State agencies establish their own specific standards for determining economic need in accordance with some broad Federal requirements.

The following broad concepts apply in the processes and standards for determining the client's ability to pay for vocational rehabilitation standards:

Vocational rehabilitation is a temporary service of enduring value. The specific objective of providing vocational rehabilitation services to the handicapped individual is to enable him to engage in remunerative employment. It follows that standards, policies and procedures developed by the State agency should be based on the concept of assisting the individual as necessary for a temporary period at the end of which he can take his place among his neighbors as a working member of the community.

Processes and standards should assist to preserve and strengthen the individual's self-reliance. It is important that all standards, policies and procedures, and methods of work with the individual be such as to help the individual to become self-reliant and achieve his maximum independence.

The individual should understand his responsibilities and the basis for services. Federal and State rehabilitation laws and regulations establish the basis upon which individuals are afforded services through the program. In dealing with the disabled individual the State agency is obligated to acquaint him with the services available through the agency and the conditions under which individuals qualify for them, and to provide services in accordance with those conditions. It is also obligated to acquaint him with the responsibilities and obligations he incurs by accepting the agency's services.

Equitable treatment of individuals is essential in a public program. It is essential that individuals in similar circumstances be given similar consideration on an objective reasonable basis and be accorded equitable treatment under the laws.

The individual's need under State standards is the basis for planning and providing services. The individual's need for services is the basis for planning and providing the specific services necessary for his rehabilitation in accordance with State standards and policy.

Quality and quantity of services are sufficient to accomplish the individual's rehabilitation. When rehabilitation services are undertaken for an individual, they must be sufficient in quality and quantity if he is to reach the goal of becoming a working member of the community. It would be uneconomical to establish standards or limits which would keep the individual from reaching this goal.

Constructive and adequate processes are necessary for effective and economical administration. In common with all programs it is important that State vocational rehabilitation agencies maintain standards and methods of operation that are effective and economical in the light of the program objective.

Utilization of Community Resources

The extent and manner in which community resources are used is a reflection of the counselor's concept of his role in serving the needs of the handicapped and in relating his services to other community programs. The counselor should recognize that the vocational rehabilitation program is only a part of the total array of services provided by the community in order to meet the needs of the handicapped. A basic community understanding of the role of the counselor is a great aid in seeking and developing such resources.

The productive use of related programs and professions in the counselor's territory depends upon the following: the counselor's knowledge of the principles and fields of service of related professions and agencies; awareness of the specific and potential resources for services to the disabled; and adoption of effective ways of developing and working with the resources in the community.

Services and other assistance through the vocational rehabilitation agency fall into three general categories. These are, (1) services which the State agency furnishes directly through its own staff; (2) services which it obtains from physicians, schools, rehabilitation centers, hospitals, and others, and (3) assistance obtained from cooperating agencies and individuals.

Services from community resources may be furnished directly to the client, his family or others involved in his rehabilitation or they may involve consultation with the counselor, participation through advisory committees, or special task force groups. The rehabilitation process is composed of many elements in addition to those within the immediate province of the counselor.

The need for training or physical restoration services and for assistance in locating employment opportunities are problems frequently encountered and solved with the help of related agencies and services. Other problems fall into the broad category of personal, family, financial and other individualized needs, ranging from obtaining transportation to and from a job, to securing pastoral advice.

Some of the types of community resources which the rehabilitation counselor might need to utilize in providing actual case services are: government agencies, civic and service clubs, voluntary agencies and services, institutions for public service, professional persons, and advisory committees.

The effective counselor recognizes that many of the services upon which the rehabilitation of the individual depends, must be provided by non-rehabilitation agencies. However, before seeking these services, the counselor needs to know enough about the resource to have confidence that it can actually assist his client. Conversely, so that the resource may spend its time most profitably, it should be given a thorough explanation of the client's problem. The counselor needs to maintain professional relationships with the appropriate personnel of other agencies and keeps himself posted on their programs. Lines of communication need to be kept open. The counselor should bring participating resources into the planning stages to make them more closely aware of the developments by which the rehabilitation objective is chosen and reached by the client. The counselor should then keep the participating resources informed about the client's progress and the outcome of their services.

Criteria for Selection of Facilities

The facilities which the counselor utilizes should meet the standards as set forth in the individual State Plan. The staff members of the facility should be fully qualified to render the service they are responsible for. The physical plant of the facility must be adequate to provide the services needed and accommodate the client. The facility should keep the counselor properly informed of the client's

progress. It needs to be reliable, trustworthy and ethical. The costs of services at the facility are in line with costs at other facilities furnishing comparable services under similar circumstances. It can provide the services necessary for the individual client at the time needed, and has a reputation of establishing satisfactory relationships with counselors and clients. Unless contra-indicated, client's choice of facility should be respected by the counselor. Finally, the facility has a fairly consistent record of obtaining effective results.

Justification of Services

In order to justify servicesthe counselor should prepare an individual written plan covering the services needed by the client. The plan should show there is a good possibility that the services will meet the client's needs as disclosed by the case study and will lead to the client's chosen vocational objective. The plan should indicate that the provision of services will entail a "substantial service" enabling the counselor to terminate the case as "closed-employed", when satisfactory job adjustment has been made. State agency standards and policy should be met if a plan of services is to be acceptable.

In those instances in which counseling is the only rehabilitation service other than placement provided a client, it should be assured that the counseling was substantial and contributed to the client's job adjustment. Subsequent to a complete medical and vocational diagnosis, counseling usually includes the following counselor activities.

1. Acquainting the client with the advantages of choosing a vocation in the light of careful study and analysis.

2. Assisting the client in cultivating a self-understanding of his capacities, aptitudes, and interests, based on the data secured during the case study.

3. Providing the client with information about occupations, education, health, and other community services and facilities.

4. Assisting the client in selecting suitable and realistic vocational goals.

5. Planning with the client a program for the attainment of selected vocational goals.

The counselor should recognize that not all of these activities may be present in every counseling situation. They are descriptive, however, of the framework within which counseling may be considered as substantial.

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Provision of Services

A planned program of services is generally approved prior to actually authorizing any vendor to begin providing services. A written authorization is sent to the vendor with a description of the type of service, proposed expenditures, method of reporting and billing. If the cost of a portion of the service is to be paid by the client, or other resource, the vendor is informed.

The client is informed of the services, starting date, conditions of contract and regulations of the agency pertaining to the services. If release forms, receipts or other signed statements are required prior to initiation of services, they are secured by the counselor. A written statement is sent to the client confirming the plan of service prior to the starting date. Sufficient time is allowed between approval and starting date so that the client can reasonably be expected to meet the schedule.

The counseling relationship continues during the entire period of service. In cases where the client is from out of the district or state, and is under the supervision of another person during the period of services, complete information needs to be given to the supervising office and the client is informed of the availability of counseling services.

Description of Services

Services which may be included in a rehabilitation plan are: physical restoration, training, maintenance, transportation, establishment of business enterprises,provision of tools, equipment and licenses, other goods and services, and placement.

Physical restoration services are defined as "medical or medically related services necessary to correct or substantially modify within a reasonable period of time a physical or mental condition which is stable or slowly progressive." More specifically, "physical restoration services" include: (1) Medical or surgical treatment by general practitioners or medical specialists; (2) psychiatric treatment; (3) dentistry; (4) nursing services; (5) hospitalization (either inpatient or outpatient care) and clinic services; (6) convalescent, nursing or rest home care; (7) drugs and supplies; (8) prosthetic devices essential to obtaining or retaining employment; (9) physical therapy; (10) occupational therapy; (11) medically directed speech or hearing therapy; (12) physical rehabilitation in a rehabilitation facility; (13) treatment of medical complications and emergencies, either acute or chronic, which are associated with or arise out of the provision of physical restoration services, or are inherent in the condition under treatment; and (14) other medical or medically related rehabilitation services." (Regulations, Section 401.1 (m))

Training is only one of a comprehensive list of vocational rehabilitation services. However, it takes on special significance because of its contribution to the individual's job adjustment. Through

training, the individual not only prepares for employment but is better able to compete for jobs, and in periods of declining employment is better able to hold the job he has. Training provides an individual with marketable knowledge and skills which are especially desirable when it is necessary to overcome employer prejudice toward physically or mentally handicapped persons. Training gives to the disabled individual something which can assist him significantly in competing with others who are seeking employment. During periods of fluctuation in the labor market, the fact that a handicapped person has had training may very well spell the difference between job security and a long period of idleness.

Training also contributes in other ways to the individual's total adjustment. Many clients are enabled through their successful performance in training to develop the self-confidence and emotional stability that are so vital to their personal and vocational adjustment. The training program is often a strong motivational experience in helping the disabled individual to establish a satisfactory role for the first time, or to rediscover his role in the community.

If training is to mean all that it should to a disabled person, it is important that the conditions under which it is given are satisfactory and that the client recognizes his obligations in insuring the success of the training program.

Rehabilitation training includes any type of training that may be necessary in order to rehabilitate a disabled individual. This definition recognizes that a state agency may utilize public and private training facilities; or may provide such services directly by assigning staff members to this function, by employing instructors, or by operating training facilities.

The training provided by a counselor may be classified into three broad categories; vocational, prevocational, or personal-adjustment training. These terms have reference to the training provided in the State-Federal vocational rehabilitation program, and are not intended for general use in other professional fields.

Vocational training includes any organized form of instruction which provides the knowledges and skills that are essential for performing the tasks involved in an occupation. Such knowledges and skills may be acquired through training in an institution, on the job, by correspondence, by tutors, or through a combination of any or all of these methods. Vocational training may be given for any occupation - professional, semi-professional, technical, clerical, agricultural - or for any of the skilled or semi-skilled trades.

Prevocational training includes any form of academic or basic training given for the acquisition of background knowledge or skill prerequisite or preparatory to vocational training, or to employment where the primary occupational knowledge and skills are learned on the job. It includes training which is related to vocational courses or to

employment, by complementing or facilitating the acquisition of the knowledge and skills required for entry into an occupation. In vocational rehabilitation, prevocational training may also include training given for the purpose of removing an educational deficiency which interferes with the fullest utilization of the occupational knowledge or skills already possessed by a disabled individual.

Personal-adjustment training includes any training given for any one or a combination of the following reasons:

1. To assist the individual to acquire personal habits, attitudes, and skills that will enable him to function effectively in spite of his disability.

2. To develop or increase work tolerance prior to engaging in prevocational or vocational training, or in employment.

3. To develop work habits and to orient the individual to the world of work.

4. To provide skills or techniques for the specific purpose of enabling the individual to compensate for the loss of a member of the body or the loss of a sensory function.

One of the services supplementary to other vocational rehabilitation services is maintenance. Maintenance means "payments to cover the handicapped individual's basic living expenses, such as food, shelter, clothing, health maintenance, and other subsistence expenses essential to achieving the individual's vocational rehabilitation objective." (Regulations, Sec. 401.1 (j)).

Maintenance is furnished when required, in order to enable an individual to derive full benefit of other vocational rehabilitation services being provided. It may be provided at any time, in connection with vocational rehabilitation services, from date of initiation of such services, including diagnostic services, up to a reasonable period following placement.

Transportation is another of the supplementary services in vocational rehabilitation. "Transportation is considered to mean the necessary travel and related costs in connection with transporting handicapped individuals for the purpose of providing diagnostic or other vocational rehabilitation services under the State plan. Transportation includes costs of travel and subsistence during travel (or per diem allowances in lieu of subsistence) for handicapped individuals and their attendants or escorts, where such assistance is needed." (Regulations, Sec. 401.28).

Another duty of the counselor is to assist the handicapped person in obtaining an occupational license when the job objective requires it. An occupational license is "any license, permit or other written authority

required by a State, city or other governmental unit to be obtained in order to enter an occupation." (Regulations, Sec. 401.1 (1)).

When necessary to the client's vocational rehabilitation the counselor may provide tools, equipment and initial stocks (including livestock) and supplies; equipment and initial stock and supplies for vending stands; and necessary shelters in connection with the foregoing items. (Regulations Sec. 401.41 (f)). These services may be supplied to the client, if needed, in connection with employment by others or in the establishment of a small business enterprise whether operated by the client directly or under the management and supervision of the rehabilitation agency.

Placement is a service that is provided by the State agency for all individuals accepted for rehabilitation. (Regulations Sec. 401.30). The agency sets standards for determining if the client is suitably employed and provides for a reasonable period of follow-up after placement to assure that the vocational rehabilitation of the client has been successfully achieved.

Other goods and services necessary to rendering handicapped individuals fit to engage in a remunerative occupation may be provided, but Federal financial participation is not available in any expenditure made either directly or indirectly on behalf of the handicapped individual for the purchase of any land or for the purchase and erection of any building or buildings (Regulations Sec. 401.41 (g)).

Placement and Follow-up

Counselors, too often, assume that the client will make his own efforts to find employment and that he knows just how to go about doing this. Dependency is often a concomitant of disability, and the handicapped person frequently becomes used to having other people, including counselors, do things for him. Without a direct word of encouragement to seek his own employment, the client may just wait for the counselor to find him a job. Employers have attested both emotionally and emphatically that many vocational rehabilitation applicants who appear before them frequently do not know how to apply for work.

Therefore, prior to formulating the actual plan of placement with the client, the counselor and client should determine that he is ready to assume the role of a worker. All necessary services will have been provided to the client; he will have sufficient work tolerance to carry out his responsibilities to his employer and co-workers; he understands his performance abilities and limitations in terms of his disability; he knows his job objective in terms of performance standards, usual wages and benefits, working conditions, opportunities for advancement; he has the skills and knowledge required for his objective; and he has the attitude of a desirable prospective employee.

The counselor is responsible for providing placement services to each client who needs that assistance. However, in addition to the counselor's efforts the client properly can and should be advised and encouraged to make efforts in his own behalf to find a suitable job. The counselor can suggest to the client who is seeking employment that he do the following things:

1. Complete and appraise a written survey of his assets and liabilities with respect to training and education, work experience, disability and personality traits so that he can objectively measure what he has to offer a potential employer and prepare himself for what and how he wants to say to the employer.

2. Question his friends for leads, watch daily papers for announcement of new plants, branch offices, stores or businesses and expansion of commercial enterprises in his area, and work closely with his counselor in the employment service.

3. Apply in person to former or new potential employers whenever possible. If first application must be made by letter or phone, ask for a personal interview.

4. Prepare and take to each employment interview a personal data sheet with his name, address and telephone number and summary of qualifications which can be left with the employer.

5. Obtain and complete several different employment application forms; review them critically with the counselor for neatness and content as the employer would.

The counselor's responsibility to the client does not end when the client has been placed. Before the case can be "closed as rehabilitated" the counselor should follow-up to determine that the employment is suitable, i.e., that the client is satisfactorily employed according to his capabilities and potentials and that the employer too is satisfied.

The timing of the initial follow-up and the period to be allotted for this service are controlled by the particular circumstances of the individual case. It might be advisable to follow-up on the day of, or within the first few days after placement in one case; in another the employer and/or the client may resent this as unwarranted meddling. Usually, follow-up is initiated 15-30 days after placement. This allows opportunity for the client to adjust to the job situation and judge his satisfaction in it as well as its suitability for him; the employer and co-workers too will have formed some opinions on the client's acceptability as a worker and as a person.

Additional follow-up might be scheduled at sixty and ninety day intervals after the placement. The suitability of the placement can

generally be determined within these periods; of course, there will always be exceptions and then follow-up must be extended.

For both the initial and subsequent follow-up contacts a schedule should be prepared. It is important that the counselor stay close to the situation so he will know how the client is adjusting, how the employer is reacting, what problems are developing which he might help to resolve, and all of the other details essential to his giving proper service to the client and to the employer.

The personal interview is preferred for the follow-up. The counselor should conduct his own follow-up study in as many cases as he can and in each case where the client is severely disabled. The follow-up can best take place on the job-site unless there are definite objections to it by the employer or client since this will permit the counselor to get the "feel" of the situation. Because of time, distances involved, familiarity with the employer and other factors, circumstances may permit or require follow-up by calling the client to the office, by telephone interview or by mail. Unless the counselor is very certain of his knowledge of the total situation, these methods are to be avoided.

In some instances the counselor may know that a representative of the employment service, social worker of the welfare office, officer of the parole board, etc., has or will make a follow-up. If the report of that visit is available to the counselor and it is adequate, the service need not be duplicated. It could, in fact, be detrimental to the client in some cases.

In interviewing the client, the counselor will be concerned with the state of the client's health, his interpersonal relations with the employer and co-workers, the adequacy of services provided by rehabilitation, amount and regularity of pay, and presence of any problems.

In interviewing the employer, the counselor will want to assess the client's acceptability as a person and as a worker, existence of any difficulties, the employer's reaction to rehabilitation in terms of the client and to any future potential disabled workers.

SUMMARY

Planning and providing services with and to vocationally handicapped individuals is a joint activity requiring the cooperative participation of client, counselor and community. The extent and manner in which community resources are used is a reflection of the counselor's concept of his role in serving the needs of the handicapped and relating himself to other programs in the community. It is of utmost importance that he become an active leader in community planning.

The effective counselor recognizes that many services upon which rehabilitation of the individual depends must be provided by non-rehabilitation sources. However, the facilities which the counselor utilizes must

meet the standards set up in the individual State plan. He should prepare a written plan showing the services required by the client and how such services will meet his individual needs and lead to the chosen vocational objective. In those instances where counseling is the only rehabilitation service, other than placement, provided to the client, it should be assured that the counseling was "substantial" and contributed to his job adjustment. The planned program of services is usually approved prior to actually authorizing any vendor to begin providing services. The client is informed of the services and the date they are to start.

The counselor's responsibility does not end with the client's placement on a job, but is continued until his follow-up contacts reveal that both client and employer feel he is an adjusted, satisfied employee.

References and Suggested Readings

1. Abramson, A., "Teamwork in Medicine." Arch. Phys. Med. and Rehab. January 1955. 36: 1: 43-45.

2. Bahlke, Anne M., "Rehabilitation of the Handicapped; the Place of the Official Agency." Med. Clinics N. Am. May 1953. 37: 3: 933-941.

3. Breul, F. R., Do They Stay Rehabilitated? Olympia, Washington: State Division of Vocational Rehabilitation, 1954.

4. Bridges, C. D., Job Placement of the Physically Handicapped. New York: McGraw-Hill Book Company, 1946.

5. Carlsen, Anne, H., "Vocational and Social Adjustment of Physically Handicapped Students." Except. Child., 1957, 23, 364-368.

6. Davis, J. E., Rehabilitation; Its Principles and Practice. New York: A. S. Barnes, 1946.

7. Dawson, V. R. & Anderson, R. H., "Placement of Rehabilitated Patients." J. Amer. Med. Assoc., 1955, 159 (6), 557-559.

8. Feintuch, A., "Improving the Employability Attitudes of difficult to place Persons." Psychological Monograph, 1955, 69, No. 7 (Whole No. 392).

9. Fletcher, F. M., Jr., "Symposium on Rehabilitation Counseling." J. Counseling Psych. 1954, 1: 4: 240-248.

10. Gendel, H., "Vocational and Medical Agencies Collaborate." Personnel and Guidance J., January 1955, 33: 5: 277-281.

11. Gorthy, W. G., Rehabilitation, a State Responsibility. New York: Institute for Crippled and Disabled, 1955. (Rehab. Ser. Series No. 10, October 10, 1955.)

12. The Handicapped in Defense, Employment of Physically Handicapped Persons at Hill Air Force Base, Utah, 1952.

13. The Handicapped Man for the Job; The Job for the Handicapped Man. National Association of Mutual Casualty Companies, New York.

14. Holland-Hibbert, J., "Some Gaps Between Theory and Practice." J. Rehab. January 1953. 7: 2-6, 9.

15. Kessler, M. S., "Job Satisfaction of Veterans Rehabilitated Under Public Law 16." Personnel & Guidance J., 1954-55, 33,78.

16. Lerner, Ruth S. and Martin, Marion. "What Happens to the College Student with a Physical Handicap?" Personnel & Guidance J. 1955, 34, 80-85.

17. Lesser, Marion S. and Darling, R. C., "Factors Prognostic for Vocational Rehabilitation Among the Physically Handicapped." Archives Physical Medicine, 1953, 34, 73-81.

18. Lipton, B. H., Hoberman, M., and Teschner, B., "Rehabilitation of the Severely Disabled." J. Rehab., 1955, 21, 8-10, 19.

19. Lunde, A. S. and Bigman, S. K., Occupational Conditions Among the Deaf, Gallaudet College, 1959, 66 pp.

20. Morton, F. L., "Management of the Physically Handicapped Personnel." Industrial Medicine, 1945, 14, 306-311.

21. Neuschutz, Louise M., Jobs for the Physically Handicapped, Beechhurst Publishing Company, 1944, 240 pp.

22. Proceedings of 7th Annual Workshop on Guidance, Training and Placement, "Counseling and Placement - Eligibility." 1954, pp. 1-32. (OVR Service Series 273, Part II).

23. Proceedings of 8th Annual Workshop on Guidance, Training, and Placement, "Counseling and Placement - Eligibility," 1955, pp. 1-47. (OVR Service Series 331, Part II).

24. Proceedings of the 10th Annual Workshop on Guidance, Training and Placement., "The Rehabilitation Counselor's Use of Rehabilitation Facilities," 1957, p. 9 (OVR Service Series 416, Part I).

25. Redkey, H., Rehabilitation Centers Today. Washington, D. C.: Government Printing Office, 1959, 231 pp.

26. Rice, L. T., The Disabled in Hospital Employment, 1954 (OVR Service Series 275).

27. Rusk, H. A., "Physical Medicine and Rehabilitation in Medical Education." J. Am. Med. Assn. October 1950, 144: 9: 730-732.

28. Selective Placement of the Handicapped. International Society for the Welfare of Cripples, New York, 1957.

29. Sheltered Workshops and Homebound Programs: A Handbook on Their Establishment and Standards of Operation. National Committee on Sheltered Workshops and Homebound Programs, New York, 1952.

30. Thomason, Bruce and Barrett, Albert M., The Placement Process in Vocational Rehabilitation Counseling, Office of Vocational Rehabilitation, Washington, D. C.: September 1960.

31. Waldrop, R. S.,"Signs of the Times in Rehabilitation." J. Rehab. March 1959, 25: 2: 4,5.

32. Wenkert, W., "Community Planning for Rehabilitation." American J. Public Health. July 1952, 42: 7: 779-783.

33. Whitehouse, F. A., "Teamwork -- A Democracy of Professions." Exceptional Children. November 1951. 18: 2: 45-52.

34. Whitten, E. B., (Editorial)"Rehabilitation Facilities." J. Rehab. January 1959. 25: 1: 1.

35. Wilson, D. V., "Rehabilitation and the International Scene." J. Rehab. May 1951. 17: 3: 3-6.

Although the specific services that are offered by the medical, psychological, social, and vocational consultant have been listed in previous chapters dealing with the rehabilitation process this chapter will, therefore, briefly present some general considerations regarding the use of consultants. For more detailed information on their specific duties refer to previous sections.

The vocational rehabilitation agency takes major responsibility for the continued movement of the handicapped person during the critical time when he is progressing toward maximum vocational efficiency. The rehabilitation counselor is the representative of the agency and is in personal contact with the client during this period. However, he must deal with other professional workers from various disciplines who are actively serving the client during this same time, or who may possess knowledge and skill necessary to the solution of baffling problems facing the client. Since it is imperative that these complex and diversified services be inter-related toward the goal of vocational rehabilitation, the counselor should communicate effectively with professional workers in all the disciplines involved. The consultant can assist the counselor to an adequate understanding of the special problems, methods of referral, technical vocabulary, etc., involved in making maximum use of other disciplines.

Functions of the Consultant

Consultants have special competencies in specialized areas, such as medicine, psychiatry, social work, therapy and employment. In pure consultation the consultant carries no continuing responsibility either for dictating or implementing a course of action. He does not determine eligibility, the vocational objective, or the plan of services. He does possess the authority of ideas; thus his recommendations should be sought, if needed, in the light of his evaluation of the problems facing the client.

Consultation is not a substitute for supervision. The supervisor has administrative authority and responsibility; the consultant the authority of special skills and ideas. Consultation supplements supervision in the advisory and teaching functions, thus contributing to the solution of case problems as well as to the professional growth of the staff.

The consultant, no matter what his area of specialization may be, has certain special skills and qualifications. Included in these are the following:

> Substantive Knowledge: He is an expert in the knowledge of his field of specialization. Whether he is working as a member of the agency's staff or in a capacity outside the agency, he should be particularly skillful in relating his special body of knowledge to the purposes and objectives of the agency as

well as to the client's problems.

Communication: He has special skills in facilitating communication, by interpretation of technical material and by putting it in terms that are meaningful and usable for rehabilitation personnel in achieving appropriate content and form for their communications to members of his own specialty group.

Teaching: The consultant has a continuing responsibility to contribute to the professional growth of the agency staff. His day-to-day contacts with staff are a major vehicle for this teaching function, but he also plays a substantial role in more organized and formal training experiences.

Problem Solving: The problems facing a disabled person are so varied and occur in such unique combination that no one individual or discipline can effectively deal with the total situation. The consultant, therefore, becomes a necessary part of the problem solving group or team.

Specific Activities of the Consultant

The consultant may be effectively used by the counselor in both individual and group conferences. Individual conferences provide for face to face meetings around the problems of particular cases, or in the area of the consultant's competency. In the instance of group conferences there may be a case staffing. This is actually an individual case conference, carried out in a group setting for the purpose of importing knowledge and techniques.

District and state-wide staff meetings may include planned participation of the consultant in staff meetings of the agency. A consultant's substantial knowledge is frequently called upon, in institutes, workshops, and seminars, for specific teaching purposes in specialized areas. In the orientation of new counselors and in the on-going staff development program, the consultant takes an active part in planned programs in his area of specialty.

Guidelines for Consultation

Both counselor and consultant must recognize the importance of scheduled appointments, regularly adhered to. It is the responsibility of the counselor to prepare for the consultant a concise and well organized presentation of the facts and data to be discussed in the conference. The counselor also has responsibility for recording as a part in his case notes the major factors in the conference, indicating his further planning and action in the light of the consultation.

It is important for the counselor to realize that consultation as here described applies equally to the services rendered by a specialized professional person attached as a full or part-time member of the agency

staff and to services rendered by a specialist not so employed. The fact that the agency makes this service available to the counselor in no way lessens his responsibility to develop and use community resources and facilities for consultation, and to enter into working relationships with specialized professional persons around problems of cases and program, such as day-to-day relationships with examining physicians, social workers, psychologists and personnel directors.

SUMMARY

In summary the consultant serves as a catalyst and stimulator and a motivator in the areas of serious rehabilitation problems. He has the authority of ideas, but does not have authority and responsibility for the execution of these ideas or recommendations. Determinations of eligibility and vocational objectives are and remain inherent with the responsibilities of the counselor. Nevertheless, the correct use of a consultant can lead to more effective rehabilitation and the successful rehabilitation of greater numbers of handicapped people.

References and Suggested Readings

1. Bowman, Paul Hoover, "The Role of the Consultant as a Motivator of Action." Mental Hygiene. January 1959.

2. Follett, Mary Parker, Dynamic Administration: The Collected Papers of Mary Parker Follett. Edited by Henry C. Metcalf and L. Urwick. Harper, New York 1942, 320 pp.

3. Concepts of Mental Health and Consultation, Their Application in Public Health Social Work. Children's Bureau, 1959 (See especially papers included in pages 181-233).

4. Davis, Alice Taylor,"Consultation: A Function in Public Welfare Administration." Social Case Work. March 1956, pp. 113-119.

5. Lindenberg, Ruth Ellen. "Changing Traditional Patterns of Supervision." Social Work Journal. April 1957. pp. 42-46.

6. Pleydell, Albert. "The Role of the Management Consultant." Administration, Supervision and Consultation. Papers from the 1954 Social Welfare Forum, National Conference of Social Work. New York: Family Service Association of America, 1954.

7. Psychiatric Consultation for Non-Psychiatric Professional Workers. Public Health Monograph No. 53. U. S. Department of Health, Education, and Welfare, Public Health Service 1958.

8. Ragensberg, Jeanette. "Utilizing the Contribution of Psychiatric Staff Within an Agency." Social Case Work. June 1951. pp. 231-236.

9. Siegel, Doris. "Consultation: Some Guiding Principles." Administra- Supervision and Consultation. Papers from the 1954 Social Welfare Forum, National Conference of Social Work. New York: Family Service Association of America, 1954. pp. 98-114.

The purpose of this section is to discuss the principles as well as the content of case recording in vocational rehabilitation counseling. The correct professional use of records in serving clients will also be outlined. The section will not emphasize specific methods of case recording as such, nor the mechanics of case recording, since it is not intended, by means of these recommendations, to standardize case recording practices.

Although the section contains material on the content of records, it does not attempt to describe such content in detail. That has been done in the sections of the manual involving the client study. Neither will this section concern itself with the reports and forms that are used for fiscal purposes or statistical reporting by the various States.

Purposes of Case Recording

Although the purposes of case recording are threefold, it can be readily noted that the counselor's primary interest lies in the first purpose listed. The purposes are: (1) facilitation of the client study process, (2) improvement of staff and of program, and (3) other administrative purposes.

The primary purpose of case recording is to facilitate the client study process by bringing into focus all the pertinent data about the client. This enables the counselor to understand his client; to counsel with him; to help him plan his future adjustment; to help him secure necessary medical, educational, and other rehabilitation services; and, finally to help him find and adjust to suitable employment.

It provides the information that is needed for establishing a professional relationship with the client. During early contacts with the client the case recording should emphasize his history, his present adjustment and environmental situation, and the objective measures of, or reports on his physical and mental capacities. This provides an informational basis for the counseling relationship and provides substantiation for planned programs of services.

It provides continuity with respect to the information, the evaluations, and the services provided. For each interview or case contact the written record provides the point of departure for additional services. Also, when there is personnel turnover or when more than one person participates in the development of the case, the case record enables each professional participant to coordinate his work with that of other professional workers.

Case recording contributes to sound thinking by the counselor. It does so in two ways: (1) Since no case record will reproduce everything that is said or done in a case, the counselor is forced to be selective in what he records. He must sift out and select those items of information

that have the greatest significance in evaluation of the client's present capacities and adjustment, and in predicting how and in what area his future adjustment can best be facilitated. (2) The writing of any diagnostic or evaluative summary calls for sound logical thinking. The counselor's writings record the meaning which he sees in the client's experience; the significance he places on the test results, examinations, or observed behavior of the client; or gives his justification of a proposed course of action.

Case records are indispensable as a device by which the agency maintains and improves the quality of its operations, and tests the effectiveness of the services it provides. Good case records are essential for supervision, are an important source of teaching materials for the agency's in-service training program, provide information for making an evaluation of the program, and contain priceless data for research.

Case recording is used in many ways to facilitate the administration of the program. Program administrators must rely on case records to assure themselves that the acceptance of cases, the provision of counseling and planning services, and the purchase of services meet the criteria that are established by law and regulations. The director and his staff use case records for program interpretation. Case recording is often useful to correct or offset an erroneous or unfair interpretation of the agency performance. Good administration is promoted by well kept case records.

Content of Case Record

Rehabilitation services are provided on an individualized basis to meet the identified needs of clients. Some clients are relatively well adjusted and do not need extensive services; others have problems which are deep-seated, varied, and which require detailed study evaluation, and counseling. There can be no specific rules, therefore, regarding the amount of information that should be included in the case record. However, the following general criteria are pertinent.

Since the client is the focus of the counselor's attention, the case folder should provide enough information about his past experiences and present situation that both personal and agency objectives can be properly achieved or identified.

The data about the client should be adequate to indicate whether he is eligible for services, whether he can be made employable, and if so in what job or occupational area, and what services should be provided. The information recorded in each case should at least be sufficient to support an appraisal of the client's physical capacities, mental and educational abilities, vocational skills and interests, personal and social adjustment, financial circumstances, and motivation for employment. Those areas that are important in understanding the client's total situation, or in substantiating the suitability of the services requested by the client, are to be recorded in considerably more detail. There is considerable

variation not only in the total volume of information that is recorded in a given case, but also in the adjustment areas that are emphasized by the recording.

Any item of information which helps the counselor to understand the client's behavior should be explored. The significance of this is that any standardized list of questions, such as a survey-interview form, will be inadequate in most cases. For adequate recording there must be some written record of the additional information which is secured in many if not most cases.

The recorded information about a client should be both accurate and reliable. If there are any conflicting or contradictory reports, they are to be fully explained or reconciled. Reported observations or generalizations about a client are recorded in such a way that the reliability of the reports can be determined. The source of all recorded data about the client should be clearly indicated.

It is of little value to record items of information without indicating the meaning of the information to the client and to the counselor. Some data, for example, are especially important in understanding a client's emotional adjustment, and should be interpreted in these terms. This might be true of such types of client experiences as the following: a series of hospitalizations, a report of juvenile delinquency or discord in or disruption of the family. Other data may be especially pertinent in understanding the client's occupational adjustment, and is to be interpreted in relationship to these areas. These include for instance such client experiences as: past employment in specific jobs, the parents' opinions with respect to suitable work for the client, or unusual skills or aptitudes possessed by the client.

The total case file should be evaluated from time to time in order to support the determinations or decisions made or the actions taken. The medical, psychometric, social, vocational, and psychological data must be integrated and evaluated in terms of the client's needs and potentialities. The written record should give a complete picture of the program of services by which the client is prepared for and enabled to find suitable employment.

The progress of the client should be recorded. This will include, first, an accurate chronological record of activities or events -- for example, dates on which the client received a prosthetic appliance or began work on a new job. It will include, second, a description of the services or events and an evaluation of the client's response to or benefit from the appliance, the occupational equipment, or whatever the service may be.

The contributions of the counselor in serving a client should be indicated by the record. It should give an account of his contacts and of the arrangements he works out. It should reflect the major problems which he encounters in working with the client and in helping him to secure services from community agencies; and indicate the nature and extent of his professional contribution to the progress of the case.

The case recording will reflect the effectiveness of the services. While a detailed evaluation is not called for, there should be enough information for a reviewer of the record to tell whether the medical treatment or surgery was successful, whether the trainee developed the vocational skills that were planned, and whether the personal counseling and social adjustments which were the counselor's contribution resulted in an improvement in the client's situation.

Recommended Guides for a Case Recording System

An appropriate staff member of the state agency should be responsible for developing basic standards for case recording. The agency standards are usually issued in a case manual or other appropriate medium. In their establishment the following suggested standards are worthy of consideration.

It is assumed that most agencies will continue to use certain basic case study forms. Agencies will probably use the survey-interview forms and the individual plan form in all cases, and provide for optional use of certain other forms. However, no set of case study forms can adequately reflect the dynamics of the client study process. Throughout each step in the process there must be some narrative recording to depict the sequence of the client's progress, to reveal the counselor's diagnostic interpretations and counseling goals, and to indicate the client's movement toward a suitable vocational adjustment.

The most practicable style of recording would seem to be the condensed narrative. The word "condensed" implies that the records will be as brief and concise as is consistent with an understanding of the client and his circumstances; it implies that the counselor will select the significant material and record only that. The use of marginal headings makes it easier to group the data according to subject matter and also facilitates a review of the record.

Summary recording is an effective device for keeping records concise. Although it may be used for various purposes and at various points in the client study process, it is particularly useful in recording what happens during interviews with or on behalf of a client. Although most interviews are recorded, it is desirable under certain circumstances to summarize in one entry the information secured or the action taken in the course of several contacts. Thus, if several persons are contacted in a single day, in the course of the investigation of the client's application and need for service, all such contacts may be recorded in a single summarized report if the source of the data are made clear in the report. Even though each interview results in useful and important information, if they occur reasonably close together in point of time, they may be summarized for the record in a single entry.

Another situation in which summary recording may be used is: the client has easy access to the counselor and sees him frequently -- several times a month perhaps, in this instance, the counselor may not need to record each interview separately. It probably would be

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adequate to summarize once periodically the progress of the case since the last entry.

Process recording, though not generally used, may be useful for certain purposes. In some cases it may be desirable for the record to be detailed enough to reflect the counseling and interviewing techniques used by the counselor. To do this it may be necessary to occasionally dictate as nearly a verbatim account of the interview as possible. It may be desirable, for example, to record a very detailed account of the client's experiences and behavior in order to support an evaluation of emotional maladjustment. These detailed records, however, are to be compiled only when they are specifically needed for counseling, research,staff training, or for intensified forms of staff development through supervision.

If all case materials are permanently fastened in the folder in an orderly sequence, it will not be necessary to enter in the narrative a notation of every action or contact in the case. However, if the agency desires to maintain a running record that makes reference to all case actions, care should be taken to avoid repetition. A written report of a medical or psychological examination should tell its own story; if any narrative is needed, other than a mere notation of the receipt of the report, it should be to interpret the report, or to relate it to other data or to the client's total situation. Likewise, when letters are received and answered the correspondence itself is nearly always adequate for the record and no narrative explanations would be recorded.

In developing the case record system duplication is to be avoided. Duplicate information within a case folder often requires unnecessary time and effort. The case folder should be maintained in an orderly manner in order that counselors and supervisors will not be discouraged from using it. All materials should be filed in definite sequence and should be stapled or otherwise fastened so that the sequence will not be easily disturbed. The materials should be legible. The case record is most useful when it contains only the pertinent materials.

SUMMARY

The recording of the case information is necessary for: (1) a consistent and logical sequence of the client's progress in counseling from one contact to the next, and from one counselor to another; (2) administrative purposes such as counselor and program evaluation and development; and (3) providing a basis for research.

A great deal of skill is required on the part of the counselor in order to include all the pertinent case data and still maintain a concise useful record.

Various methods of recording may be used with equal success. The choice of method may be governed by state policy, but otherwise it is determined by the needs of a particular client and the personal preference of the counselor.

References and Suggested Readings

1. Barbin, T. H.,"The Case Record in Psychological Counseling." J. of Applied Psychology, 1940, 24, 184-197. Reprinted in Readings in the Clinical Method in Psychology (Edited by Watson), New York: Harper and Brothers, 1949, 740 pp.

2. Blear, Genevieve, "Suggestions on Recording Techniques." J. of Social Casework, January 1949, p. 25.

3. Hackheis, Gertrude, "Suggestions on Recording Techniques." J. of Social Casework, January 1949. p. 20.

4. Hamilton, G., Principles of Social Case Recording, New York: Columbia University Press, 1948.

5. Little, Ruby, "Diagnostic Recording." J. of Social Casework, January 1949, p. 15.

6. Proceedings of the 2nd Annual GTP Workshop, A Guide to the Case History Data Needed for Rehabilitation Counseling, 1949, pp 11-25.

7. Proceedings of the 3rd Annual GTP Workshop, The Value of Case Recording and Standards for Case Recording in Public Assistance Agencies. 1951, pp 14-20 (OVR Rehab. Service Series No. 150).

8. Riggs, Frieda W., "Case Reading in Public Assistance Supervision, the Family" J. of Social Casework, February 1949, p. 370.

9. Rothney, J. W. M., and Boens, B. A., Counseling the Individual Student. New York: William Sloane Associates, Inc., 1949. 364 pp. (Chapter 11: General Criteria Governing the Collection of Data for Counseling.)

10. Sytz, Florence, "Teaching Recording." J. of Social Casework. December 1949, p. 399.

11. Taylor, Alice L., Case Recording in the Administration of Public Assistance, Federal Security Agency, Bureau of Public Assistance, Washington, D. C., 1950, 56 pp.

12. Thomas, R. E., "Case Records are For Use." J. of Rehabilitation. April 1947, p. 15.

13. Thorne, F. C., "Personality Counseling, Brandon Vermont." J. of Clinical Psychology, 1950, 491 pp. (Chapter 9: Diagnosis and Therapeutic Implications of the Case History).

14. Tod, R. J. N., "Recording of Process as an Aid to Casework Supervision." Social Work, October 1947, Vol. 4., pp 92-98.

15. Wechsler, Claine M., and Dover, Frances T., "Casework Recording as a Reflection of Casework Practice." Child Welfare, XXVIII, No. 9, November 1949.

16. OVR Manual, Chapter 24, Section 1, Case Recording.

PART FOUR

OTHER CONSIDERATIONS IN REHABILITATION COUNSELING

ADMINISTRATIVE DUTIES OF VOCATIONAL REHABILITATION COUNSELORS

The primary responsibility for the administration of the vocational rehabilitation program lies in the hands of the administrative and supervisory staff. Nevertheless, the new counselor will, as a part of his responsibilities, be expected to perform a number of administrative duties.

The administrative duties logically divide themselves into two groups, one involving services to clients and another group which is concerned with actual office management. The former is concerned with case finding, caseload management, field trips and public relations; while the latter pertains to office operation and preparation and utilization of reports.

Administrative Duties Involving Services to Clients

The first mentioned of these duties, case findings, has been previously dealt with in the section Identification of Persons in Need of Rehabilitation Services. Case finding was described as the process of acquainting the public with the objectives and services of the rehabilitation agency; locating all disabled individuals in need of and who might be eligible for vocational rehabilitation services; informing them of the services available through the vocational rehabilitation agency; and finally ascertaining whether they are interested in receiving such services.

Caseload Management

Caseload management involves the attainment of balance in services provided to the clients; the attainment of a reasonable balance in service to the various disability classifications; and, the maintenance of an active case load of appropriate size.

Balance suggests that the counselor maintain some minimum and maximum number of clients in each case status. The counselor will consciously strive for balance in providing the various services available through vocational rehabilitation, however, he should not do so at the expense of any individual client. It is not rational to demand of the individual counselor that he have a definite number of cases undergoing physical restoration or in training at any one time as this makes no allowance for variations due to such factors as: the geographic area served by the counselor; the cultural backgrounds presented by clients; the setting in which counselor works, that is, in an institution which has primary responsibility for providing some physical or mental restorative services versus a routine office setting, and finally state agency policies and practices.

Not all cases can be successfully rehabilitated. The continued absence of any cases closed "for other reasons" or "unemployed" should cause the counselor to examine the selective process by which he determines

which clients have a reasonable expectation of becoming vocationally rehabilitated. It is essential that the counselor develop his caseload to the point that he has an acceptable number of cases in service, so that he may produce an acceptable number of closures.

Some degree of balance in serving clients with multiple handicaps is desirable. However, some leeway in required closures should be allowed for counselors serving a restricted caseload or special disability group, e.g., counselor for the deaf, the blind, the mentally retarded, etc. The counselor should be called upon to explain the prolonged absence of any severely disabled or of any particular disability group from his active caseload. This may call for some self-analysis on his part and can lead to potential growth and development.

The counselor should be able to demonstrate that he has an active caseload, and one in which case movement is easily observed. Case movement may be described as goal oriented progress which the counselor and others are able to "see". The attainment of the goal is generally thought of as contributing to the client's adjustment to a job, but the relationship need not be a direct one. Case movement can be readily assessed by the counselor through a reference to his referral register and master list of cases. Clients who remain in any status for what appears to be an abnormal length of time; for example, those who have been referred but not accepted 6 to 12 months after the counselor receives the case, are worthy of some additional consideration or attention. Everyone will agree that the counselor should have an adequate supply of clients to satisfy production demands; however, the only static case immediately accessible in satisfying production goals is the case "in employment".

Other illustrations of cases lacking case movement are: (1) those of clients who have been "accepted for service" but after several months and even years have never received services beyond diagnosis; (2) those of clients who are still "convalescing" long after the date the attending physician indicated they were ready to return to training or employment; (3) those of clients who have been "ready for employment" in a worker's market for excessive periods of time; and (4) those of clients who remain in "interrupted" status after repeated counselor contacts.

Field work activities must be carefully planned if the counselor is to carry out this element of the total job in an efficient manner. The portion of the counselor's working time these activities require will vary with the nature of the geographical territory assigned to the counselor. Counselors with large rural territories usually spend much more time in field work activities than those working in metropolitan areas.

Most states are divided into districts to which individual counselors are assigned. The counselor is the sole full-time representative of the rehabilitation agency within his territory. He has the responsibility for making contact with agencies, facilities, employers

and other individuals and resources within his territory. The counselor can maintain contacts with agencies and facilities by setting up and holding to a regular itinerary including the specific dates he plans to make contacts with each major agency. This enables the agency to prepare its referrals and provide help in interviewing, diagnosing, planning and supervising services.

Whenever possible the counselor will conserve time by arranging for a central headquarters in each area where clients may be interviewed. The clients will be notified in advance of the time and place of the appointment. In rare instances when the counselor cannot keep his appointments, the clients should be provided with a satisfactory substitute or explanation.

Time spent on organization of the counselor's field work activities promotes efficiency through conservation of travel time, economy of program operation, optimum utilization of counselor's energies and notification of district and central offices of counselor's whereabouts.

Some of the preparations for field work in which the counselor can engage are as follows: (1) prepare a kit of standard materials for each field trip including necessary agency forms, copies of laws, regulations, state policies, list of agencies, facilities and employers and occupational information; (2) prepare pertinent notes from client's case folder including statement of purpose of each contact; (3) provide a written method of recording decisions and other relevant matters essential to dictating upon return to the office; and (4) prepare for promotion of the program in the territory by listing specific contacts to be made and through participation in development of programs promote community responsibility for the disabled.

Public Relations

The intensity with which public relation activities will be pursued will vary from state to state. The following, however, are some of the basic objectives which the vocational rehabilitation agency will strive for in any state:

1. To substantially increase the number of handicapped persons informed of the availability of rehabilitation services.

2. To foster acceptance of the rehabilitation program and appreciation of its needs by authorities in the community.

3. To develop employer acceptance of the handicapped.

4. To stimulate promising students and established professionals in fields allied to vocational rehabilitation to enter the vocational rehabilitation field -- that is, to encourage the training of counselors, social workers, doctors, nurses, therapists, etc.

5. To encourage the development of research and research projects designed to improve and/or originate methods and techniques for coping with the problems of the handicapped.

6. To help mobilize support and enthusiasm for vocational rehabilitation and its objectives at the grass roots -- at the community level where the program must, of necessity, succeed or fail.

7. To foster the best possible relations between the state vocational rehabilitation agency and other agencies, public and private, involved in coping with the problems of the handicapped.

8. To respond to queries, complaints and criticisms from whatever source as rapidly as possible consistent with available resources, and to funnel all constructive criticisms to those staff members most directly concerned for appropriate corrective action.

9. To maintain the best possible relations with and access to the media of communications -- i.e., press, radio, TV.

Within the context of the previously cited general objectives, the efficient counselor can do much to disseminate required information and to foster community acceptance for the agency and program he represents. He should, however, understand the relationship between public relations and overall agency goals as well as the mechanics of the public relations process. Some public relations factors have a bearing on the achievement of both public relations and overall vocational rehabilitation objectives. No public program can grow and improve if it does not have the support of the community and, through the community, the legislative and administrative powers which control that program's purse-strings. The first requirement in achieving community support is to render sound service. Sound service is possible only if those who should be informed of its availability are so informed, and if the community at large understands the nature of the service, its scope, its quality, and its impact on the individual citizen as well as upon the nation. A service such as vocational rehabilitation can, in practice, be no better or no worse than what important elements of the public think it to be. Legislators will appropriate, governors and mayors will be friendly, and the press will keep its criticism to a minimum if the vocational rehabilitation agency does a good job and makes others aware of it.

Salient factors to bear in mind in the preparation of any material for a media which serves the general public are: (1) simplicity of data; (2) local angle wherever possible; (3) conciseness; (4) inclusion of human interest material if possible; (5) direction of material to proper staff person of press, etc.; and (6) respect for press and other deadlines.

Promptness and efficiency in the handling of correspondence from any segment of the public are very directly related to good public relations, because, in the eyes of the correspondent they place a value upon both the agency involved and the official making the reply. Promptness and efficiency are particularly important in the handling of queries which bear upon the personal well-being of the correspondent in either the physical, emotional or economic sense. As a general rule, letters should be answered within two to five days of receipt if at all possible. Systematic filing, tickler and routing systems are invaluable if correspondence is to be handled properly.

A well-rounded public relations program takes into consideration the views, position in the community, and activities of major social and civic groups. Service clubs, veterans groups, chambers of commerce, labor unions -- all of these and other organizations play a key role in the molding of public opinion and in influencing legislative and executive action bearing on the objectives of the vocational rehabilitation program. These groups can be most cooperative in fostering these objectives if properly approached and judiciously cultivated.

Office Management

Efficient office management is an important factor contributing to the counselor's overall efficiency in discharging his total responsibility as a staff member. The counselor should leave the impression with the client that his problems are of vital concern to the agency. His requests and complaints are given courteous attention and prompt consideration.

The office operation leaves the general impression with the public that the program is operated in a professional and business-like manner. High value is placed upon public approval and support. Requests from other professions and agencies are given courteous and prompt consideration. There is an atmosphere of respect for colleagues and members of other professional disciplines with whom the counselor communicates. The rehabilitation agency merits a position on the same level as other professional agencies.

The counselor utilizes the services of the office clerical staff effectively. The secretary may be delegated duties for handling routine correspondence, records and files, reports to district and state office staff and, in the counselor's absence, for responding to client's routine problems, as well as problems raised by other agencies and individuals. The secretary's skill in resolving even the most minor incident in the counselor's absence oftimes determines the perception of vocational rehabilitation by the referral source.

Making and Utilizing Reports

Today many vocational rehabilitation operations and services are stopped and/or started through the initiation of letters, memoranda,

telegrams, telephone calls, interviews, and reports by the counselor. Many counselor actions will come to the attention of the State agency and the Office of Vocational Rehabilitation via the written report. A counselor may be asked for an oral report but often a written report may be required. The results of counselor reporting is seen in planning, direction, control and analysis by both the State agency and the Office of Vocational Rehabilitation based on his information and that received from other sources by the agency. Good reports facilitate all phases of the program and make for efficiency when well adapted to the needs of a specific organization. Lastly, good, well written reports based on accurate recorded data often form the basis for and justification of actions, policies, etc.

Any modern operation requires quality reports based on accurate information. In vocational rehabilitation the quality of the report reflects the work of the State agency and its staff. Records and reports can become burdensome and it has been said that they are only valuable insofar as management is prudent in their use; to keep too many records and require too many reports merely to "have data on hand" results in unnecessary expense and a hindrance to management. A good record should receive a favorable answer to the following: (1) Is it really necessary? (2) Does it duplicate any present record? (3) Is it a practical record for the organization? (4) How is the recording going to be used? (5) What constructive action will be possible from this record? (6) How much will it cost, and is the expenditure justifiable?

Finally, a few words about the specific reports that are required by the Office of Vocational Rehabilitation. A report is said to be a written statement based on a collection of records and usually expresses an interpretive summary of the record content. At present, several statistical reports are required by the Office of Vocational Rehabilitation. The information transmitted on these reports is used to help the State agencies by furnishing data to them on a national, regional and State-agency basis to facilitate and improve the operations of the State agencies; to help to keep OVR's Central Office and regional staff sufficiently informed of what is happening in the program that they can effectively carry out their responsibilities; to inform the Department of Health, Education and Welfare and the Bureau of the Budget about the vocational rehabilitation program; and to inform Congress about the program.

Summary analyses of these reports are made available through articles in OVR's bi-monthly publication, Rehabilitation Record, reports issued as part of the Rehabilitation Service Series, and in other ways. For further details as to the purpose and content of the required reports, please refer to Chapter 13 of the Vocational Rehabilitation Manual, Office of Vocational Rehabilitation.

SUMMARY

The counselor's administrative duties are many and varied although the supervisory staff has primary responsibility for administration of the vocational rehabilitation program. The administrative duties of the counselor involve service to clients and office management.

The counselor is responsible for case finding, caseload management, field trips, public relations, office operation and preparation and utilization of reports. The secretary may be delegated certain duties pertaining to office operation and routine client contact in the counselor's absence.

REHABILITATION COUNSELING PROBLEMS AND TECHNIQUES

A major topic for discussion among students training in vocational rehabilitation counseling, as well as among experienced counselors, is the matter of counseling techniques. The discussion generally focuses upon a "straw man" continuum of directive versus non-directive counseling. When pressed to do so, the majority of beginning counselors end up by defining directive counseling as a form of counseling in which you do most of the talking and give advice; and non-directive counseling as a form of counseling in which you listen. Unfortunately the issues involved are not so easily defined; maybe because when we really understand what the major writers and authorities on both sides of this point are saying we find that actually they are more alike than they are different, and that the great issues may be nothing more than mere semantic differences. In reality, all counseling is for the good of the client and thus "client-centered", regardless of the verbal techniques that are used. What the counselor needs to convey is an atmosphere of warmth and acceptance, a concentration on the needs and problems of the handicapped individual; and if he successfully conveys these feelings, either verbally or non-verbally, how much he talks and how much he listens are often minor details.

Nevertheless, there do seem to be some situational, environmental, personal and personality factors related to the job of the vocational rehabilitation counselor that present unusual problems, and call for research leading to the development of new and more effective counseling techniques. The problems seem to be related to three areas: (1) Specific environmental problem; (2) The nature of the referrals and the size of the counselors case load; and (3) Personal variables related to the counselor himself. A brief discussion of each of these points follows:

Environmental and Situational Factors

The following variables seem to present unusual problems to the rehabilitation counselor.

1. The amount of time that he has available for any one client is often related to the size of the counselor's case load, and administrative requirements regarding an acceptable number of closed cases for any given period.

2. The amount of travel involved in some localities imposes a restriction on both how often a counselor can see a client as well as how much time he can give him at any one time. Also involved is a matter of finding adequate facilities for counseling when he is out in the field. There seems to be little question but that minimally adequate facilities for counseling are generally available, but oftentimes they are not adequate in terms of the privacy needed for some of the material that the client would prefer to discuss.

3. The amount of counselor time and energy devoted to

administrative duties also limits the amount of counseling a counselor can realistically be expected to provide to his clients. These duties fall into two major areas: those related to arranging for services; and those related to records and agency forms. While admitting that both duties are essential to the rehabilitation counselor's job, the fact remains that they can often make serious demands on the amount of time that he was available for counseling service to his clients.

The Nature of the Case Load

Within this area the following variables seem to present some unusual problems to the vocational rehabilitation counselor.

1. The number of cases referred with problems of a serious nature. This type of case takes a great deal of time and money to rehabilitate. As indicated in the section of this manual dealing with case load management, a counselor is limited in the number of such cases that he can carry at any one given time, particularly if both intensive counseling and co-ordination of services are required.

2. The number of cases referred exhibiting passive-dependent personality traits. A study by Wilcox (30) indicates that passive-dependency as a personality trait is much more prevalent among vocational rehabilitation clients than among the general population. This is understandable in the light of the feeling of many writers that "dependency in men" is one of the major readjustment problems we face in rehabilitation. Wilcox's study further indicates that passive-dependency is much more prevalent among referrals from welfare agencies, than among referrals from other sources. His data would suggest that up to twenty-five per cent of the clients accepted for services who were referred from welfare agencies exhibit passive-dependency traits to such an extent that they would seriously interfere with their ability to participate actively in a rehabilitation plan. Working with cases of this nature, particularly if the counselor is naive as to the real dynamics of the client's behavior, can be discouraging and often result in feelings of disillusionment on the part of the counselor.

3. The number of cases who have retreated from the world of work and who fail to respond to ordinary motivational techniques is quite high. It seems that rehabilitation counseling services need to be offered in close proximity to the onset of disability, in order to be most effective. Many times referrals are delayed, and by the time the counselor makes contact with the client he has already begun to withdraw from the world of work. This is particularly true of mental hospital referrals. In some cases it means that each day

they remain in the hospital their chances for rehabilitation are less. Yet surprisingly enough, a study by Gwaltney (7) indicated that even the regressed, or so-called "backward" patient, still retains an ideal self concept of a working, contributing individual. This suggests that their rehabilitation potential might be greater than we are now realizing if we could perfect our techniques to the degree that we are able to help them.

Personal Variables Within the Counselor

1. Many of the problems that a rehabilitation counselor encounters are serious in nature and challenge the professional skills of all the professions who work with them. If a counselor has not received adequate training before attempting to help such individuals and can understand the dynamics of their problems, he can often become discouraged and even depressed over the hopelessness of some of the problems that are presented. Counselors need help and constant supervision in this area in order to maintain good mental hygiene on their own part. They need to develop the capacity to help their clients without becoming over-identified personally with their clients' problems.

2. In some instances a relatively low salary schedule may not only prevent a rehabilitation agency from hiring the best qualified counselors but may also be a source of discouragement and poor morale, when a counselor feels he is not making enough money to support his family adequately.

3. In some areas travel demands are great, and some professional counselors may prefer to work for another agency that may not require such extensive traveling, thus allowing more time for counseling and related service activities.

4. Rehabilitation is only now beginning to come into its own as a professional area of work. This trend has been aided by the training funds that were made available from Public Law 565 and the resulting establishment of training programs in universities with national reputations and stature in the general area of counselor training. Many people who have not previously been interested in rehabilitation counseling as a field of work are now beginning to see it as a field that offers a real professional future and unlimited opportunities to help other people.

Counseling Techniques

Within the past several years well known authorities in the field of rehabilitation counseling such as Patterson (16), (17), Lofquist (13), Hamilton (9), and Wright (32) have published books on the topic of

rehabilitation counseling. These books provide basic material in the area of counseling techniques. The matter of exactly what technique to use in attempting to stimulate motivation in a handicapped individual remains relatively unanswered. We have no reason to assume that the techniques that apply to the non-handicapped will not work equally well with the handicapped, since their problems and needs are basically the same as other human beings. Yet, there is no question but that the very nature of their disability often limits the type or types of adjustive techniques that they can use, thus presenting unusual problems for the counselor.

One of the topics often discussed by counselors is related to the application of Rogerian techniques versus more directive techniques in counseling. It might be well to go back to Rogers' book "Counseling and Psychotherapy", published in 1942, and restate the conditions Rogers himself has indicated are necessary before Rogerian techniques are applicable. The criteria as stated below are quoted directly from Rogers' (23) book.(Quoted by permission of the publisher, Houghton-Mifflin, New York):

> "Conditions Indicating Counseling or Psychotherapy. From the material given in the previous portions of this chapter, it would seem that direct counseling treatment of the individual, involving planned and continued contacts, is advisable provided all of the following conditions exist:
>
> 1. "The individual is under a degree of tension, arising from incompatible personal desires or from the conflict of social and environmental demands with individual needs. The tension and stress so created are greater than the stress involved in expressing his feelings about his problems.
>
> 2. " The individual has some capacity to cope with life. He possesses adequate ability and stability to exercise some control over the elements of his situation. The circumstances with which he is faced are not so adverse or so unchangeable as to make it impossible for him to control or alter them.
>
> 3. "There is an opportunity for the individual to express his conflicting tensions in planned contacts with the counselor.
>
> 4. "He is able to express these tensions and conflicts either verbally or through other media. A conscious desire for help is advantageous, but not entirely necessary.
>
> 5. "He is reasonably independent, either emotionally or spatially, of close family control.
>
> 6. "He is reasonably free from excessive instabilities, particularly of an organic nature.

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7. "He possesses adequate intelligence for coping with his life situation, with an intelligence rating of dull-normal or above.

8. "He is of suitable age - old enough to deal somewhat independently with life, young enough to retain some elasticity of adjustment. In terms of chronological age this might mean roughly from ten to sixty."

A close examination of these criteria would suggest that some of them are not being met by many clients applying for rehabilitation services. It seems unfair, therefore, to criticize Rogerian techniques as being non-applicable when Rogers himself has never made any claims that they are the best for every client.

In summary, it seems that good counseling techniques may work wherever they are used, regardless of the nature of the clientele. Nevertheless, there is a clearly indicated need for extensive and long-term research in counseling methods to indicate what techniques, or combinations of techniques and services, will motivate many of the clients referred to rehabilitation, who have withdrawn from the world of work and have lost their inner motivation.

References and Suggested Readings

1. Barker, R. G. and Others. Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability. New York: Social Science Research Council, 1953, 440 pp.

2. Bordin, E. S., "Diagnosis in Counseling and Psychotherapy." Educ. Psychol. Measmt. 1946, 6, 169-184.

3. Brayfield, A. H., Readings in Modern Methods of Counseling. New York: Appleton-Century-Crofts, 1950. 526 pp.

4. Callis, R., Polmantier, P. C., and Roeber, E. R., A Casebook of Counseling. New York: Appleton-Century-Crofts, 1955.

5. Gilbert, W. M., "Counseling: Therapy and Diagnosis." Annual Rev. Psychol. Stanford, California: Annual Reviews, 1952, Vol. 3 351-380.

6. Goodenough, Florence L., Exceptional Children, New York: Appleton-Century-Crofts, 1956.

7. Gwaltney, H. O., "Group Identification in Mental Hospital Patients." Unpublished doctoral dissertation, 1959, University of Missouri.

8. Hahn, M. E. and MacLean, M. S., Counseling Psychology. New York: McGraw-Hill, 1955.

9. Hamilton, K. W., Counseling the Handicapped in the Rehabilitation Process. New York: Ronald, 1950.

10. Hamrin, S. A. and Paulson, Blanche B., Counseling Adolescents. Chicago: Science Research Associates, 1950.

11. Kessler, H. H., Rehabilitation of the Physically Disabled. New York: Columbia University Press, 1953.

12. Lerner, Ruth S., and Martin, Marion. "What Happens to the College Students with a Physical Handicap?" Personnel Guidance Journal. 1955, 34, pp. 30-85.

13. Lofquist, L. F., Vocational Counseling with the Physically Handicapped. New York: Appleton-Century-Crofts, 1957.

14. Mathewson, R. H., Guidance Policy and Practice. (Rev. Ed.) New York: Harper and Bros., 1955.

15. Newland, T. E., Psychological Assessment of Exceptional Children and Youth." In Cruickshank, W. M. (Ed.) Psychology of Exceptional Children and Youth. Englewood Cliffs, New Jersey: Prentice-Hall, 1955.

16. Patterson, C. H., Counseling the Emotionally Disturbed. New York: Harper and Brothers, 1958, 458 pp.

17. Patterson, C. H., Counseling and Psychotherapy; Theory and Practice. New York: Harper and Brothers, 1959.

18. Pattison, H. A. (Ed.) The Handicapped and Their Rehabilitation. Springfield, Illinois: Thomas Co., 1957, 944 pp.

19. Pepinsky, H. F. and Pepinsky, Pauline N., Counseling Theory and Practice. New York: Ronald, 1954.

20. Pepinsky, H. B., "The Selection and Use of Diagnostic Categories in Clinical Counseling." Appl. Psychol. Monogr. 1948, No. 15.

21. Robinson, F. P., "Are Non-Directive Techniques Sometimes too Directive?" J. Clin. Psychol. 1946, 2, 368-371.

22. Rogers, C. R., Client-Centered Therapy. New York: Houghton-Mifflin, 1951, 560 pp.

23. Rogers, C. R., Counseling and Psychotherapy. New York: Houghton-Mifflin, 1942. 450 pp.

24. Rusk, H. A. and Taylor, E. J., Living with a Disability. New York: Blakiston, 1953.

25. Shaffer, L. F. and Shoben, E. J., Jr., The Psychology of Adjustment. Boston: Houghton-Mifflin Co., 1956.

26. Sullivan, H. S., Conceptions of Modern Psychiatry. Washington: William Alanson White Psychiatric Foundation, 1947.

27. Tyler, Leona. The Work of the Counselor. New York: Appleton-Century-Crofts, 1953.

28. U. S. Department of Health, Education, and Welfare. Public Health Service. Health Statistics from the U. S. National Health Survey: Preliminary Report on Disability, U. S., July-September 1957, Washington, D. C.: U. S. Government Printing Office, 1958.

29. Waldrop, R., "The Rehabilitative Aspects of Counseling in U. S." Department of Health, Education and Welfare, Office of Vocational Rehabilitation. Reports of Proceedings, Seventh Annual Workshop on Guidance, Training and Placement. Washington 1954.

30. Wilcox, R. K., Passive Dependency in Rehabilitation, Unpublished doctoral dissertation, 1958, University of Missouri.

31. Widdowson, D. C., Thirty Cardinal Requisites for an Adequate Education Program for Hospitalized Children." Except. Child. 1954, 20, pp. 251-252, 258.

32. Wright, Beatrice A., Physical Disability - A Psychological Approach. New York: Harper and Brothers, 1960.

THE REHABILITATION COUNSELOR AS A PROFESSIONAL PERSON

In the past 40 years the State-Federal rehabilitation programs have rehabilitated nearly one million handicapped persons. It is significant that 750,000 of these have been rehabilitated since 1943, thus attesting to the recent accelerated growth of rehabilitation programs in the United States. The vast expansion of vocational rehabilitation in recent times has placed a spotlight on rehabilitation counseling as a profession. Public Law 565, passed by Congress in 1954, providing for the expansion of State-Federal programs, included funds for a training program for rehabilitation counselors. The momentum for professionalization of rehabilitation counseling was thus provided, bringing with it the difficult problems of determining the nature and extent of training, desirable personal characteristics of trainees, and the precise role of the rehabilitation counselor.

In developing the theme of the rehabilitation counselor as a professional person, an overview of historical antecedents of the present status of rehabilitation counseling will be presented. Then the feeling of some authorities regarding the desirable personal and training requirements for rehabilitation counselors will be examined. Lastly, the problem of interprofessional relationships and other pertinent problems facing the counselor in rehabilitation will be explored.

Tracing the Development

One means of charting the development of rehabilitation counseling is to view it in the larger context of the recent expansion in the personnel field. Patterson (47) comments on the large scale professionalization of psychology as a recent development stimulated and accelerated by World War II. The dramatic change that has taken place in psychology from its early laboratory-experimental and teaching focus to a profession with a large service responsibility is aptly illustrated in the data presented by Daniel (17) which shows an increase from 18 per cent in 1916, to 56.7 per cent in 1951 of non-teaching positions held by American Psychological Association Members. Commensurate with this shift in focus was the tremendous numerical growth as revealed in figures showing an increase in APA Membership of from 535 in 1926 to a total in excess of 18,000 in 1958.

Hall and Warren (24) refer to the expansion in the social services as a recent phenomenon in American life, wherein significant growth is felt to be a product of the enactment of relevant legislation at the State and Federal levels; of the leadership of industry and labor in fulfilling community responsibilities including obligation for employee welfare; and, in general, increased community understanding and acceptance of the need for such services.

As previously indicated, perhaps the most prominent motivating factor in arousal of public interest in restoration of the handicapped individual to gainful employment was the Second World War. The pervasive

impact of this event seemed to foster the development of a strong sense of public responsibility for the war injured, the direct result of which was the expansion of vocational rehabilitation programs for the disabled. Through the momentum of this movement, accelerated programs were initiated by the Veterans Administration and other governmental and voluntary agencies that led to a significant increase in rehabilitation facilities and in a general expansion of a vocational rehabilitation program for civilians, and, the need for rehabilitation personnel.

In 1952, the Task Force on the Handicapped listed the outstanding developments in rehabilitation for the preceding decade. A look at some of those developments provides a good overall picture of future trends. Their list of the major points included:

1. The vast increase in medical knowledge and improvement in medical care.

2. The remarkable progress made in the treatment of mental disease.

3. The rapid development of specialized rehabilitation centers.

4. The growth of the State-Federal programs of vocational rehabilitation.

5. The marked improvement in prosthetic and self-help devices.

6. The increase in the number, size, and quality of voluntary organizations serving the handicapped.

Thus, it may be noted that the early objectives of rehabilitation consisting in the main of protection, custodial care, and maintenance, were broadened in scope to encompass the concept of the goals and skills of many different professions being fused and focused on the special needs of the handicapped person, to the end of his becoming a useful productive member of society. In a large sense, the movement was away from a fragmented approach to the individual and his rehabilitation needs, and towards a dynamic approach embracing an effective interchange of ideas among professional workers.

The modern concept of rehabilitation as a comprehensive service developed out of years of experience with handicapped persons and repeated demonstrations of the need for treating the whole patient (73). The efficacy of treatment of the client within his total life sphere by medical and non-medical services in a comprehensive rehabilitation program has been tangibly demonstrated in the restoration of severely handicapped persons to independent and useful lives. It is this concept which is basic to the emergence of rehabilitation counseling as an accepted profession, for in it is encompassed a recognition of the principle that large expenditures of professional time and money are of little ultimate value unless implemented by a vocational plan that

is in accord with the handicapped person's physical and mental condition (33). In such a process, the rehabilitation counselor is called upon to perform the crucial task of helping the individual make the best use of his positive vocational aspects to the end of making a good vocational adjustment.

The concept of the "rehabilitation team" conveys the idea of a cooperative effort by a number of professional workers in rehabilitation working toward a common goal, i.e., maximum rehabilitation of a handicapped person. We can say with some assurance that the rehabilitation counselor is now on the team as a full fledged member. Acceptance as a member of the rehabilitation team has come, ironically, at a critical period when many people are becoming weary of the naive perception of the team concept as a "cure-all" for every rehabilitation problem. Yet, there exists a clear challenge for the rehabilitation counselor to demonstrate that he, as holds true for other team members, can offer something unique and substantial to the solution of the handicapped person's problems.

Training and Personal Qualifications of the Rehabilitation Counselor

There are rather wide variations in viewpoints among professional rehabilitation workers as to just what should constitute desirable knowledge and skills for the counselor. Whitten in 1954, observed that there were, at that time, no generally acknowledged criteria for evaluating the qualifications for a rehabilitation counselor. This was not true of other disciplines engaged in rehabilitation, for unlike the rehabilitation counselor, other professional workers in rehabilitation had approved schools, established curricula, and general standards by which a determination of qualifications of a person to perform the functions of the profession he represents could be made. In the six years following, considerable effort has been made toward clarifying the problem of suitable criteria for evaluating the job of rehabilitation counselors; nevertheless, we still see a general lack of agreement among persons in rehabilitation regarding the precise ingredients of desirable training, and, as a consequence, the particular profession with which rehabilitation counseling is to form primary identification. However, there are data available which tend to illustrate some positive movement and to suggest significant long-term trends. For example, a recently activated joint committee representing the university coordinators of rehabilitation counselor training programs and the training committee of the Council of State Directors of Vocational Rehabilitation shows great promise of arriving at realistic recommendations in regard to curriculum content in counselor training.

Personal Qualifications

Desirable qualities for counselors have been enumerated in a number of recent publications in the field of counseling. If we view counseling as a single, unitary process, these become applicable to the question of counseling with the handicapped, or rehabilitation

counseling. Generally speaking, qualifications are broad and inclusive, so much so, that we might say they could better be considered indicative of a capacity to define counseling. Patterson (46) commenting on such lists points to the fact that desired attributes include ideal characteristics for counselors and as such are not phrased in a way that is operationally meaningful.

A partial sample of these personal qualities that are considered to be desirable in counselors would include: understanding and tolerance of differences and deviations, respect for others, patience, interest in people and their problems, and emotional maturity.

The Office of Vocational Rehabilitation lists the following desirable qualities: pleasing appearance and personality, flexibility and adaptability, physical stamina, capacity to recognize and deal with the problems of individuals, interest in and understanding of the problems of the disabled, imagination, resourcefulness and initiative in meeting problem situations.

Hall and Warren (24) offer a rather imposing list of fourteen personal characteristics that are considered desirable for the rehabilitation counselor. A partial listing of these would include: sensitivity to rights and feelings of others, strong interest in fellow human beings, emotional poise, optimism, confidence in the humanitarianism of people, creativity, and imagination, sound judgment, emotional maturity, flexibility, culture, capacity for organization, intellectual capabilities.

In examining such lists of desirable personal characteristics for rehabilitation counselors, it becomes clear that rehabilitation counseling demands more of a person than many occupations. Good academic ability, emotional sensitivity, sound judgment, maturity, and stability, all are factors which, ideally, the counselor should possess and that affect the quality of the counseling relationship, be it performed in a rehabilitation agency or in any other professional setting. Individual counselors do vary in the extent to which these factors are present in their personality makeup. As such is true, varying degrees of proficiency among rehabilitation counselors in the performance of different facets of their jobs may be expected. A counselor need only look (acceptingly) among his colleagues in rehabilitation to verify the existence of vast individual differences in the degree to which various desirable personal qualifications are to be found.

Necessary Abilities, Skills and Knowledges

A list of abilities, skills, and knowledges considered necessary for rehabilitation counseling are equally as broad and impressive as those regarding personal characteristics. Those generally enumerated include:

Ability to establish and maintain a counseling relationship with individuals.

Ability to evaluate aptitudes, skills, interests, and educational background;

Ability to recognize manifestations of physical and mental disabilities and their relationship to vocational adjustment;

Ability to analyze reports furnishing medical data and to interpret the relationship of the disabilities to job requirements;

Ability to analyze occupations and workers in terms of job requirements, the skills required and the physical demands of the job;

Ability to gather occupational information and to make use of it;

Ability to evaluate training programs including the ability to determine entrance requirements, the scope of the training, the skills and techniques taught, and the relative value of similar types of training for the same job;

Ability to interpret the potential capacities and abilities of disabled persons and to secure the cooperation of employers in employing disabled persons; and

Ability to make discriminating use of available community services in meeting the needs and problems of disabled persons and to maintain a cooperative working relationship with such sources.

Hall and Warren (24) have developed a list of twenty-four knowledges and skills required of a rehabilitation counselor. Those listed include: an understanding of human growth and development; an understanding of human anatomy and physiology; an understanding of mental and emotional conditions; familiarity with medical information, therapies and prostheses; the ability to use techniques of vocational and personal counseling; the ability to analyze occupations; an understanding of community organizations and their services; the ability to do research; and, understanding of social legislation and laws pertaining to rehabilitation.

The related problem of curriculum is also discussed by Hall and Warren with the conclusion drawn that the training for rehabilitation counselors should be interdisciplinary in nature. Lee (30) writing on the problem of curriculum in rehabilitation counselor education seems to favor an interdisciplinary approach as reflected in his statement that "preparation of rehabilitation counselors involves an integration of knowledges, competencies and skills from many professional fields". Some of those listed by Lee include: medical sciences, psychology, psychiatry, occupational information, social work,

sociology, counseling and guidance.

Clements (8) states that the rehabilitation counselor must be a "combination of parent, doctor, psychologist, psychiatrist, teacher, policeman, public relations expert, personnel manager, placement specialist, and jack-of-all trades". The list of professional fields proposed by the author, from which a rehabilitation counselor draws knowledges and skills to perform these tasks, is similar to those cited previously and is again illustrative of the interdisciplinary viewpoint.

Lofquist (33) writing in the context of a VA hospital setting employs the terms "rehabilitation counselor" and "vocational counselor" interchangeably. It is interesting to find that the outline of In-Service Training for vocational counselors offered by Lofquist is the one which is used in the VA traineeship program for counseling psychologists.

Patterson (48) notes that there are an increasing number of individuals trained in psychology functioning as rehabilitation counselors compared to a decade ago when the majority came from education and social work. It is his belief that rehabilitation counselor training should be fundamentally psychological in nature. Training at the doctoral level in psychology is advocated for rehabilitation counselors working with the emotionally handicapped with the term rehabilitation psychologist proposed as a means of identifying the individual functioning at the doctoral level, trained in psychology, who performs this task. Patterson submits that the broad and inclusive list of skills, abilities, knowledges proposed for rehabilitation counselors tends to read like a roster of the complete content of social and biological sciences. As was true in the case of desirable personal qualities, the person possessing the full measure of these knowledges and abilities is non-existent.

If we accept the proposition that the many proposed lists of knowledges, abilities and skills required of the rehabilitation counselor are unrealistic, we are faced with the obvious problem of defining needed competencies in more functional terms. Illustrative of such thinking is the growing tendency for many educators engaged in counselor training to question the previous emphasis upon the interdisciplinary nature of rehabilitation counselor training, and to suggest that the role of the rehabilitation counselor be defined in terms of its unique contribution--counseling. Patterson (49) an outspoken critic of the "jack-of-all-trades" concept of counselor training points to the fact that there are"no interdisciplinary persons or profession; there are only interdisciplinary teams." He further submits that the primary function of a training program in rehabilitation counseling is to develop specialists in rehabilitation counseling and not to give the rehabilitation counselor trainee any degree of competence in other fields.

One means of evaluating current trends in the training of the professional rehabilitation counselor is to examine the current graduate programs in rehabilitation counseling sponsored by OVR. In the 1959-60 academic year, 29 universities offered a graduate program in rehabilitation

counseling, leading to a master's degree. Of these 29 seven were based in departments of psychology, 11 were located in schools or colleges of education with a primary relation to guidance and counseling programs; three were closely related to special education; five were established under interdisciplinary or interdepartmental auspices; and three were established under still other administrative arrangements.

Professional Problems

The role of the rehabilitation counselor may be expected to vary considerably from one setting to another. It will vary with the scope and province of the particular agency's program, with the physical and social setting in which the counselor works, and with the level and adequacy of the counselor's own training. At one extreme it may be a relatively well defined role consisting primarily of vocational counseling or placement. At the other extreme, the rehabilitation counselor may be required to perform multiple functions including eligibility determination, administration of psychological tests, counseling, placement, public realtions work and a variety of other functions. The locality in which a rehabilitation counselor works may have a bearing upon the nature of his job. For example, should the counselor be located in a metropolitan area where there are a vast assortment of resource people to draw on, his task will be quite different from that facing the counselor working in a rural area remote from easy access to medical, social, vocational, psychological and economic resources.

Regardless of the particular setting in which he works, the rehabilitation counselor must earn the personal respect of his professional colleagues. The degree of personal respect he is able to command will probably be a function of his ability to create a perception of himself as a professional person who knows his job and is performing it adequately (8). The problem of inter-professional relationships is crucial for the rehabilitation counselor. In rehabilitation there are numerous professions represented whose general aim is also that of returning a person to a productive and personally satisfying life, and who may have some natural reservations about the comparative newcomer - the rehabilitation counselor. McGowan (8) observes that the rehabilitation counselor may face real inter-professional difficulties unless he is in a position to offer a contribution and perform a service that others cannot offer. It is his belief that these unique services take the form of: psychological counseling, a knowledge of the world of work as it relates to a handicapped individual and the ability to integrate the individual's remaining assets both physical and psychological so that a workable vocational plan may be formulated.

Patterson (47) and Lofquist (32) refer to the need of the counselor to demonstrate his contribution to rehabilitate with contribution defined by the former as "assistance in vocational adjustment" and by the latter as "vocational planning".

In the sound and fury of inter-professional rivalry the point is too often missed that disharmony occurs for the most part at the administrative and staff levels. The problem of jurisdiction is real, to be sure, but when faced with a common job of service to handicapped persons, social workers, psychologists, rehabilitation counselors and physicians are generally capable of devising a suitable means of dividing and sharing responsibilities (35). There are simply too many handicapped persons needing help to generate much friction at the service level.

Rehabilitation as an established area of skills and techniques has created the need for professionalization of rehabilitation counseling, and the "upgrading" of counselors in state rehabilitation agencies, and coincides remarkably well with the raising of training requirements for VA vocational counselors. OVR has met the problem squarely through sponsoring graduate level training programs for rehabilitation counselors. There are strong indications of the credo "counseling is the core of the rehabilitation process" having been accepted in fact as well as principle by rehabilitation leaders.

The problem of professionalization of rehabilitation counseling may be evaluated in terms of the larger issue involving the evaluation of the status of professional workers in general. Caplow (7), describing the process of professionalization of an occupation, demonstrates that the steps in the process may be clearly identified. This is depicted in the analysis of professionalization of newspaper reporters (journalists), real estate agents (realtors), undertakers (morticians), junk dealers (salvage consultants), and laboratory technicians (medical technologists). Caplow observes that, as the new profession emerges it attempts to "take on the functions of the group just above, which it aspires to, and slough off the unwanted tasks to those below" (7). In rehabilitation counseling we may find an analogous situation in the tendency for rehabilitation counselors to look disdainfully upon such functions as job placement, public relations activities, quota requirements and clerical duties, while treating, testing, counseling, case writing and research (functions of the counseling psychologists) as desirable, high status activities.

Both Wrenn (72) and Mueller (42) state that personnel work as an emerging profession must justify its claim to certain duties and skills which are not already in the possession of other professions or the general public. The principle also applies to the question of professionalization in rehabilitation counseling. Realistic objectives and standards for rehabilitation counselors need to be formulated in such a manner as to promote professional efficiency, security, and prestige. In rehabilitation counseling there is a pressing need for control of any unjustifiable pretentiousness regarding benefits to be accrued from the counseling relationship. Related to this is a need to gear the objectives of the rehabilitation process to the training and skills of the individual counselor.

Pertinent to the issue of professionalization is the evaluation by Lofquist (32) of the prevalent tendency for counselors in rehabilitation

to disassociate themselves from the term "vocational counselor" in favor of the higher status term "psychological counselor". He notes that a number of prestige terms tend to be used as a crutch for the counselor in building up his security, e.g., "self-concept", "body image", "whole person", "self actualization", "dynamic process", or "psychotherapeutic techniques". Lofquist recommends a clearer delineation of functions in rehabilitation counseling which would help the counselor to operate ethically and confidently. It is concluded that the mastery of vocational planning by the rehabilitation counselor superseded other functions, and that the task is sufficiently complex to require the full-time attention of the counselor. Functions which involve a different orientation such as therapeutic counseling or clinical counseling are better left to the psychiatrist or counseling and clinical psychologists.

It is true, nevertheless, that there is greater simplicity in theory than in practice in separating vocational planning or counseling from psychological counseling. However, this does not negate the principle that level of training and primary agency focus define the characteristics of the proposed counseling relationship. As a professional person in rehabilitation, the counselor needs to apply this ethical principle in fulfilling his dual responsibility to clientele and to the agency. There is an ethical obligation for the rehabilitation counselor to operate within the boundaries of his own competencies. Such would imply that the counselor has an obligation not to explore personality dynamics merely because it is fascinating work, or because it may have high status. Such questionable practices may result in serious damage to both client and agency.

The counselor has a basic responsibility to the agency which employs him, which he cannot escape. In practical terms this implies that even if trained to do so, the rehabilitation counselor does not ordinarily concentrate on one aspect of his job to the detriment of other less prestigeful facets which are equally as important.

Warnath (63) writing on ethical problems facing the counselor in a public agency setting, makes certain observations which have direct relevance to rehabilitation counseling and rehabilitation counselor training. He describes the discrepancy between most practicum experiences in supervised counseling which are, "carried out with little pressure and no limitation on the number of contacts and techniques approach", as compared to the typical service agency picture of backlogged cases. Thus, a counselor trained to be alert to underlying causes of vocational confusion must learn to "avoid deeper problems unless the client offers them on his own during the discussion of the presented problems".

Another ethical question facing the rehabilitation counselor is that of counselor research in a rehabilitation agency. The counselor, particularly one who has been trained in a graduate program in rehabilitation counseling, is likely to view research as an essential part of his job. In spite of such inclination, he is quite unlikely to find complete realization of this interest in a public agency. Warnath (63)

insists that even a brief look at the operation of counseling in public agencies makes it clear that research is at best tolerated and only then if it does not interfere with other duties. On a practical level, the counselor may discover that his responsibilities to his clientele mitigate against research efforts. Budgeting time for research projects may sound like the solution, but again caseload responsibilities coupled with such factors as quota requirements, public relations work and job placement tend to erode the utility of such an approach. There is, nonetheless, a definite demand for the counselor adequately trained in research methodology to do sound research on such topics as: evaluation of services, the counseling process, normative data, etc. The counselor with such interests should attempt to gain a favorable agency attitude toward time arrangements for performing research. Research can not ordinarily be done when added to regular full-time rehabilitation counseling functions. Therefore, the counselor who seriously anticipates doing research should seek to be relieved of a portion of his normal duties to insure availability of sufficient time.

In a real sense, the professional problems facing the rehabilitation counselor may be thought of as ethical considerations. As yet, there is no published set of ethical principles for rehabilitation counseling. The American Psychological Association, (2) has published an ethical standards guide for psychologists, part of which has direct applicability to the field of counseling. Guidelines are presented which touch upon ethical priorities with the client, the public, professional relationships, etc. Considering that counseling is the basic service to be offered by the rehabilitation agency and that it undergirds the entire rehabilitation process, consideration should be given to this publication.

Professional Growth

The privileges and responsibilities associated with the profession of rehabilitation counselor demands an on-going program of professional growth. On both the State and Federal levels, there is a keen awareness of the need for maintaining pace with a changing and rapidly growing field. It is the counselor's personal responsibility to assess his level of competency in the various phases of his work, for no one can force him to learn. The counselor who desires to promote his professional growth is in an ideal position in this era of rapid growth in rehabilitation. There is an increased understanding of the training potential of day-to-day supervision. In-service training by means of agency staff or outside resource persons is offered by virtually all rehabilitation agencies. Short-term training programs for both beginning and experienced counselors are available for counselors in state rehabilitation agencies, and OVR is able to cover a large part of the expenses of training institutes that are held periodically at colleges and universities sponsoring graduate rehabilitation training.

In pursuing additional training the counselor may wish to take advantage of the educational leave provisions of his agency (if such is offered). OVR can defray part of the cost of short-term training for

counselors in a wide array of opportunities. The Journal of Rehabilitation, a bimonthly publication of the National Rehabilitation Association, prints a listing, in each issue, of current training opportunities for rehabilitation personnel. The information supplied is sufficiently comprehensive to enable the counselor to gain some idea of its pertinence to his particular professional needs.

A counselor situated near universities may arrange to take, in conjunction with his regular work schedule, certain courses, such as tests and measurements, occupational information, counseling methods, as are found useful in increasing his effectiveness as a rehabilitation counselor.

Another means of promoting the counselor's professional growth is that of membership in professional organizations. Those professional organizations a counselor may wish to affiliate with, depending upon his qualifications and interests, include: Division of Rehabilitation Counseling, American Personnel and Guidance Association (APGA), American Psychological Association (APA), The National Rehabilitation Association (NRA), and The Rehabilitation Counseling Division of NRA. Both APGA and APA specify certain training and experience requirements as requisites to professional membership. In general, both require a minimum of a master's degree in a suitable area and two years experience for membership. APA holds to the doctorate degree in psychology for full membership status but accepts for limited membership (Associate) those holding master's degrees in psychology with related experience in psychological work. In general, counselors who have completed a two year master's degree program in rehabilitation counseling qualify for membership.

NRA, the organization which is for all practical purposes synonomous with rehabilitation, is heavily committed to meeting the professional needs of rehabilitation counselors. Porter (53) Chairman of the NRA Committee on Professional Standards and Relationships states that one of the purposes of the Association is "to advance rehabilitation for all physically and mentally handicapped persons" and lists as one of the means of accomplishing this goal the development of professional opportunities and standards for rehabilitation personnel. A special division of rehabilitation counseling has been established by NRA which serves the purpose of bringing counselors together primarily on an interest basis rather than a particular discipline basis. It may be pointed out that NRA serves the unique function of bringing together persons from many professional groups, thus associating them in a close, cooperative working relationship with members of other professional groups concerned with the delivery of service to disabled persons (53). At the same time members of NRA tend to maintain affiliation with their respective professional organizations for growth and advancement in their respective disciplines, e.g., the physician with AMA, the social worker with NASW, the psychologist with APA.

SUMMARY

During the past six years, since the passage of Public Law 565 in 1954, great strides have been made toward the professionalization of the position of the rehabilitation counselor.

As pointed out during the writing of this entire manual and as emphasized in this final section, serious issues and complex problems face this growing field. Many of them will take years to solve. Yet, realizing that the aims and purposes of the profession, namely to help the handicapped to help themselves, are just and good, there seems little doubt that the issues and problems presented to counselors, trainees, and administrators, will be met and solved.

References and Suggested Readings

1. Anderson, R. P., "The Rehabilitation Counselor as Counselor." J. of Rehabilitation, Vol. XXIV, 2: March-April, 1958, 4-5; 18.

2. American Psychological Association. Ethical Standards for Psychologists. Washington, D. C.: 1953.

3. Beardsley, S., "The Ideal Vocational Counselor." Occupations. 1948. 26: 528-531.

4. Borden, E. S., Psychological Counseling. New York: Appleton-Century-Crofts, 1953.

5. Caldwell, Betty M., "Role Similarity on the Rehabilitation Team." J. Rehabilitation. Vol. 25, No. 2, March-April 1959, 11-13.

6. Cantrell, Dorothy, "Training the Rehabilitation Counselor." Personnel and Guidance J., 6: February 1958, 382-387.

7. Caplow, T., The Sociology of Work. Minneapolis: University of Minnesota Press, 1954.

8. Clements, S. W., McGowan, J. F., Johnston, L. T., and McCavitt, M. E., "What is a Rehabilitation Counselor? - A Symposium." J. of Rehab., Vol. XXIII, 3: May-June, 57, 6-12.

9. Committee on Counselor Training, Division of Counseling and Guidance, American Psychological Association. "Recommended Standards for Training Counseling Psychologists at the Doctorate Level." American Psychologist. 1952, 7: 175-181.

10. Committee on Counselor Training, Division of Counseling and Guidance, American Psychological Association. "The Practicum Training of Counseling Psychologists." American Psychologist. 1952, 7: 189-191.

11. Committee on Subdoctoral Education of the Education and Training Board (A Report of). "The Training of Technical Workers in Psychology at the Subdoctoral Level." American Psychologist, 1955, 10: 541-545.

12. Committee on Personnel Standards and Training, National Rehabilitation Association. "Personnel Standards and Training." J. of Rehabil. 1951, (No. 3) :26.

13. Committee on Personnel Standards and Training, National Rehabilitation Association. "Personnel Standards and Training." J. of Rehabil. 1952, 18 (No. 3) :19.

14. Cottle, W. C., "Personal Characteristics of Counselors: Review of the Literature." Personnel and Guidance J. 1953, 31: 445-450.

15. Counselor Preparation. New York: National Vocational Guidance Association. 1949.

16. Dabelstein, D., "Counseling in the Rehabilitation Services." J. of Clinical Psychology. 1946, 2: 112-116.

17. Daniel, R. S. and Couttit, C. M., Professional Problems in Psychology. New York: Prentice-Hall, 1953.

18. DiMichael, S. G., "The Professed and Measured Interests of Vocational Rehabilitation Counselors." Educational and Psychological Measmt. 1949, 9:59-72.

19. Finch, F. H., "Qualifications for Rehabilitation Counselors." Occupation. 1937, 15: 628-630.

20. Fletcher, F. M., Jr., "The Role of Counseling Psychology in Rehabilitation Counseling." J. of Counseling Psychol. Vol. 1, No. 4, Winter 1954, 240-243.

21. Gustad, J. W., "Inter-group Problems in the Development of Rehabilitation Counseling." J. of Counseling Psychol. 1954, 1: 243-246.

22. Hahn, M. E. and MacLean, M. S., Counseling Psychology. New York: McGraw-Hill, 1955.

23. Hahn, M. E., "The Training of Rehabilitation Counselors." J. of Counseling Psychology, 1954, 1:246-248.

24. Hall, J. H. and Warren, S. L. (Editors) Rehabilitation Counselor Preparation, Washington, D. C.: National Rehabilitation Assn. 1956.

25. Hamilton, K. W., Counseling the Handicapped in the Rehabilitation Process. Ronald Press, New York 1950.

577241 O-61-12

26. Hart, D. J. and Lifton, W. M., "Of Things to Come - Automation and Counseling." Personnel and Guidance J. 4: December 1958, 282-286.

27. Hunt, J., "The Rehabilitation Counselor and the Future." J. of Rehabilitation, Vol. XXIV, 5: September-October 1958, 4-7; 15.

28. Institute for Human Adjustment. Training of Psychological Counselors. Ann Arbor, Michigan: University of Michigan Press, 1950.

29. Jager, H. A.,"Trends in Counselor Training." Occupation. 1948, 26: 477-482.

30. Lee, J. J., "The Role of the University in the Counselor Education Programs." J. of Rehabilitation. 1955, 21 (5) :4-5, 14.

31. Levine, L. S., and Pence, Janet W., "A Training Program for Rehabilitation Counselor." J. of Rehabilitation. 1953, 19 (1): 16-17, 20.

32. Lofquist, L. H., "An Operational Definition of Rehabilitation Counseling." J. of Rehabilitation. Vol. XXV. 4: July-August 1959.

33. Lofquist, L. H., Vocational Counseling with the Physically Handicapped. New York: Appleton-Century-Crofts, 1957.

34. Mason, M. P.,"Expanding Functions of Vocational Counselors in VA Hospitals." Occupations. 1951, 30: 30-32.

35. Mathewson, R. H., Shobew, E. J., Jr., and Mitchell, H. E., "Symposium on Interprofessional Relations." J. of Counseling Psychology. Vol. 2,

36. Mathewson, R. H., "The General Guidance Counselor." Personnel and Guidance J. 1954, 32: 544-547.

37. Mayo, L. W., "Rehabilitation and Social Work." J. of Rehab. Vol. XXIV 1: January-February 1958, 4-5: 15.

38. Miller, L. M., Garrett, J. F., and Stewart, N.,"Opportunity: Rehabilitation Counseling." Personnel and Guidance J. April 1955.

39. Miller, C. H., "Backgrounds of Counselor Preparation." Personnel and Guidance J., 1954, 33: 101-103.

40. Miller, L. M. (Editor) Counselor Preparation. New York: National Vocational Guidance Association, 1949.

41. Moore, B. V., and Bouthilet, Lorraine, "The VA Program for Counseling Psychologists." American Psychologist. 1952, 7: 684-685.

42. Mueller, Kate. "Criteria for Evaluating Professional Status." Personnel and Guidance J., 6: February 1959, 410-417.

43. National Council on Rehabilitation. Report of the Committee on the Process of Rehabilitation. Second Session, December 1945, New York: The Council, 1945.

44. Patterson, C. H., "Is the Team Concept Obsolete?" J. of Rehabil. Vol. 25, No. 2, March-April 1959, 9-10.

45. Patterson, C. H., Counseling and Psychotherapy: Theory and Practice. New York: Harper and Brothers 1959.

46. Patterson, C. H., "The Interdisciplinary Nature of Rehabilitation Counselor Training." Personnel and Guidance J. 5: January 1958, 310-313.

47. Patterson, C. H., "The Counselor's Responsibility in Rehabilitation." J. of Rehabilitation, Vol. XXIV, 1: January-February 1958.

48. Patterson, C. H., "Counselor or Coordinator?" J. of Rehabilitation. Vol. XXIII, 3: May-June 1957, 13-15.

49. Patterson, C. H., Counseling the Emotionally Disturbed. New York: Harper and Brothers, 1959.

50. Pattison, H. A. (Editor) The Handicapped and Their Rehabilitation. Springfield: Thomas 1957. Philosophy, Operation and Effectiveness of Physical Medicine and Rehabilitation. pp. 5-41.

51. Pepinsky, H. B., Counseling Theory and Practice. New York: Ronald Press, 1954.

52. Pierson, G. A., "Utilizing Internships in Preparation of Counselors." Occupations, 1950, 29: 92-94.

53. Porter, Edgar B., "Meeting the Professional Needs of NRA Members." J. of Rehabilitation. July-August 1959, 26.

54. Report of the Committee on Rehabilitation of the American Medical Association. J. of Rehabilitation, Vol. XXIV. 1: January-February 1958, p. 6.

55. Robinson, F. P., Principles and Procedures in Student Counseling. New York: Harper, 1950.

56. Rosse, A. A. and Peters, J. S. II., "Rehabilitation Counselors in Public Agencies." Personnel and Guidance J., 7: March 1958, 486-488.

57. Sanderson, H., Basic Concepts in Vocational Guidance. New York: McGraw-Hill, 1954.

58. Shartle, C. L., "Occupations in Psychology." American Psychol. 1946, 1: 559-582.

59. Super, D. E., "Transition: From Vocational Guidance to Counseling Psychology." J. of Counsel. Psychol. 1955, 2: 3-9.

60. Thrush, R. S., "An Agency in Transition: The Case Study of a Counseling Center." J. of Counsel. Psychol. Vol. 4, No. 3:183-190.

61. Tyler, Leona E., The Work of the Counselor. New York: Appleton-Century-Crofts, 1953.

62. U. S. Office of Vocational Rehabilitation, Department of Health, Education and Welfare. Rehabilitation Teaching Grants for Rehabilitation Counseling. Washington, D. C.: March 28, 1955. Mimeographed.

63. Warnath, C. F., "Ethics, Training, Research: Some Problems for the Counseling Psychologist in an Institutional Setting." J. of Counsel. Psychol. Vol. 3, No. 4: Winter 1956, 280-285.

64. Washington, F. B., "Social Work and Vocational Guidance." Occupations, 1936, 14: 547-552.

65. Wertz, H., "The Role of the Guidance Worker in the Schools." Personnel and Guidance J. 4: December 1958, 282-286.

66. Whitten, E. B., "Concerning the Rehabilitation Counselor (Editorial)" J. of Rehab. 1954, 20 (3): 2.

67. Whitten, E. B., " The Rehabilitation Counselor (Editorial)", J. of Rehab. 1951, 17 (6): 2,7.

68. Williams, R. H., Vocational Rehabilitation Personnel Working in the Psychiatric Field. Bethesda, Md.: Public Health Service, National Institutes of Health, U. S. Department of Health, Education, and Welfare, 1953. Mimeographed.

69. Williamson, E. G., and Bordin, E. S., Occupational Rehabilitation Counseling. Annals of the American Academy of Political and Social Science, 1945, 239: 175-181.

70. Wrenn, C. G., "Status and Role of the School Counselor." Personnel and Guidance J. 3: November 1957, 175-183.

71. Wrenn, C. G.,"Training of Vocational Guidance Workers." Occupations. 1951, 29: 414-419.

72. Wrenn, C. G., and Darley, J. G., "An Appraisal of the Professional Status of Personnel Work." In Williamson, E. G. (Ed.), Trends in Student Personnel Work. Minneapolis: Univ. of Minn. Press 1949, pp. 264-287.

73. Wright, Beatrice A. (Ed.) Psychology and Rehabilitation, Washington, D. C.: American Psychological Association, 1959.

74. Wright, Beatrice A., Physical Disability - A Psychological Approach New York: Harper and Brothers, 1960.

APPENDIX I

REHABILITATION CASE MATERIALS USEFUL IN THE ORIENTATION OF NEW COUNSELORS

Case Abstracts Selected From
Proceedings of the Eighth Annual
Guidance, Training and Placement Workshop

PARTIAL CASE ABSTRACT:

This 27 year old woman, no dependents, was married to a service man and was receiving a service allotment. She was trained by the rehabilitation division as a bookkeeper. She was eligible for training because her legs were paralyzed following an accident. She used long leg braces and crutches. She was employed in the office of a large chain store where she had received on-the-job training. She was later closed as being successfully employed in a suitable objective.

About one year after she was rehabilitated at a salary of $130.00 per month, she returned to rehabilitation stating that she had been told by her doctor that he could operate on her legs and that she would be able to walk without using crutches. She requested that the rehabilitation service provide surgery and hospitalization.

The employer did not want to release client stating her work was satisfactory, that she had no trouble carrying out her duties, and that if she would stay on he would give her a raise.

DISCUSSION QUESTIONS AND EXERCISES:

1. In this case what factors should be considered in making the determination of an employment handicap?

2. If she is determined eligible and in need of physical restoration services, what factors should the rehabilitation counselor consider in his determination of financial need?

3. What distinction should be made between eligibility for vocational rehabilitation and eligibility for a specific service?

/Case Study; Evaluation and diagnosis; Provision of services; Determination of financial need/

PARTIAL CASE ABSTRACT:

A 34 year old, single man with a high school education, arrested tuberculous, is 6'4" tall and weighs 140 pounds, was trained as a linotype operator by the rehabilitation service in 1944 at which trade he has worked successfully in various places until his lungs became reinfected with tuberculosis. He had to quit his job as a linotype operator and stayed in the sanatorium for 5 to 6 months. At the present time he is under supervision of the county health officer, who has known the boy since original infection in 1939.

The county health officer contacted the rehabilitation counselor, requesting assistance for this man to go through a period of recuperation which is from 18 months to 2 years. In addition to being a linotype operator, the client has also worked as a barber with satisfactory proficiency. His type of physical condition and this occupation are not in conflict.

The county health officer recommends that the client continue barbering and has asked the rehabilitation service to provide him with barber supplies and tools and buy him a chair in order to speed up recuperation so that the client will have something to live on during this period. He lives with his parents whose sole income is from the welfare department. The county health officer states that if he can get results from new drugs and antibiotics, he feels that the client's tuberculous condition can be permanently cured.

DISCUSSION QUESTIONS AND EXERCISES:

1. What are the considerations for or against disregarding the former occupation of linotype operator?

2. What are some of the considerations involved in dealing with a case on the basis of an outside request for a specific service? What methods would you employ in meeting this situation?

3. What do you feel are the client's immediate problem(s)? What are the agency's responsibilities in providing services to meet these problems?

/Case Study; Public Information/

REHABILITATION CLIENT NO. 3

PARTIAL CASE ABSTRACT:

A 46 year old married man with 4 children ages 7 to 16 to support. They are receiving assistance from public welfare. He is 5'7" tall and weights 140 pounds. His work record is in the coal mining industry. He has not worked for the 6 years since he sustained an injury to his right hand. He had received maximum treatment and cash benefits under the United Mine Workers Welfare and Retirement Fund but during the convalescent period complained of a back disability and a rheumatic condition affecting the shoulders and arms. He was referred to rehabilitation by public welfare. He owns a small amount of personal but no real property. He has resided in the same community all of his life.

The rehabilitation process was explained to the client in detail. He has a 6th grade education and apparently has fair intelligence. His interests outside of employment are hunting and fishing. The counselor has attempted to motivate the client through a discussion of employment or training. The client usually replied that he was willing to do any kind of work. The counselor encouraged him to suggest some occupations in which he might be interested. He indicated an interest in a poultry project. One of his neighbors is a rehabilitation client who is engaged in a similar occupation. Because the client lived on rented property, which lacked proper buildings and water supply, he was advised against this program.

The rheumatism in his arms and hands seems to have bothered him recently. The use of his right hand is limited by some stiffening in the wrist but he has good use of his fingers. He makes no attempt to contact possible trainers or employers between visits with the counselor.

DISCUSSION QUESTIONS AND EXERCISES:

1. What additional factors might have been considered in the case study?

2. What problems of motivation are involved in this counseling situation?

/Case Study; Counseling and planning/

PARTIAL CASE ABSTRACT:

A 44 year old married man, with 2 dependents - his wife and one brother - has been employed as a tool room attendant with the same firm for 21 years. This man has a physical disability consisting of a cleft palate and harelip. Surgery was performed at age of 12 for correction of harelip, no surgery has been attempted on the hard palate. Medical evaluation does not recommend surgery for the palate and a prosthesis is recommended. Speech evaluation recommends a prosthesis with speech training as his speech is usually nasal with nasal emission and a rather serious articulatory defect. Graduate of high school. This man has an income of $250.00 and must contribute $15.00 monthly towards brother's keep at a county home.

DISCUSSION QUESTIONS AND EXERCISES:

1. How does this case relate to the general field of rehabilitation as compared with the objectives of vocational rehabilitation?

/Basic Concepts of Vocational Rehabilitation/

REHABILITATION CLIENT NO. 5

PARTIAL CASE ABSTRACT:

Fifty-three year old married man, father of 6 children, 1 married and 1 in the army, other 4 range in age from 12 to 18. At present the client is drawing unemployment compensation of $65.00 each 2 weeks from a railroad. He has worked as a section hand on railroad repair crew for past 7 years. Client states he is in poor health because of his teeth which are infected and draining into his right ear. Claims he "can't hardly eat and my stomach is affected."

DISCUSSION QUESTIONS AND EXERCISES:

1. Assuming, as indicated from the information, that this case has gone no further than the initial interview, what areas of case study would you select in order to identify this individual's rehabilitation problems?

2. What factors should be considered in dealing with cases where dental disorders are the basis for the disabling condition?

/Preliminary Investigation; Evaluation and Diagnosis/

PARTIAL CASE ABSTRACT:

A single 19 year old girl with less than 20/200 vision in left eye. Vision not correctable and does not alter girl's appearance. At present, she is in her first year of nursing school. School course lasts 3 years, first year is spent in college, last 2 years are spent in hospital work. The girl does not consider herself handicapped but she is eligible for vocational rehabilitation services and wants help in the payment of tuition. She has no previous work experience.

DISCUSSION QUESTIONS AND EXERCISES:

1. What effect would the fact that "The girl does not consider herself handicapped . . ." have on the counselor's decision as to whether or not further study should be made?

2. If the individual is entering an occupation which does not require binocular vision, how could you demonstrate whether or not an employment handicap exists?

/Preliminary investigation/

PARTIAL CASE ABSTRACT:

A single 35 year old man, no dependents, has been working at the same firm as an accountant for the last seventeen years. He is 5'9" and weighs 170 pounds. He developed stomach ulcers and decided he should quit his job on account of it. His employer doesn't want him to quit and his doctor tells him the ulcers can be cured more readily by proper diet and medication if he continues at work than if he stays at home with nothing to do but worry.

In spite of this, he decides to quit his job since he feels that the worries caused by it are causing his ulcers. He is now unemployed and is unwilling to take another job as an accountant for the reasons stated above. He applies to vocational rehabilitation for training to become a lawyer.

DISCUSSION QUESTIONS AND EXERCISES:

1. What additional information would be needed to make a decision as to eligibility?

2. What other types of agencies or specialists might you consult to aid you in arriving at a more complete evaluation as a basis for counseling?

3. What possible factors would you consider as being possible basis for this man's complaints and how would you relate them to your possible counseling program?

/Case Study; Evaluation and diagnosis; Provision of Services/

REHABILITATION CLIENT NO. 8

PARTIAL CASE ABSTRACT:

A 32 year old married man, with 2 dependents, worked as a logger all of his employable life, to the time when he had to discontinue this type of work due to retinal detachment, right eye. Two years later, a retinal detachment occurred, followed by retinitis proliferous, left eye. He was considered by the examining ophthalmologist to be permanently and totally blind, both eyes, and no treatment was recommended. He was poorly adjusted to his disability, insisting that he was unable to do any work whatsoever, in spite of the counselor's efforts to convince him that there are still many fields of endeavor in which he might engage. It was thought that he might begin on a small scale by learning to make and sell belts and coin purses, and that after regaining self-confidence, he could be placed in some more remunerative work, but he was not willing to try.

The following year, another ophthalmologist operated on the client's right eye for removal of cataract, but no vision was restored and he said he had developed severe pain in his eyes and head. His case was closed as unemployable.

After 3 years he returned to the counselor, stating that he was ready to cooperate. A new eye examination revealed the right eye pupil to be eccentric and an immature cataract. After-cataract membrane, left eye. Surgery on the right eye was recommended. This was done and glasses provided. He still contends that he cannot see and insists that he has stomach ulcers; however, the general medical examination revealed "normal abdomen." After discussing numerous jobs, he finally agreed that he might wash dishes at a cafe, but we have been unable to place him, to date, and he makes no effort to help .

DISCUSSION QUESTIONS AND EXERCISES:

1. Enumerate the facts which might lead to the counselor's statement "he was poorly adjusted to his disability...."
2. What are the things to be considered in analyzing an individual's adjustment to his disabilities? (What about the stomach complaint?)
3. Of what value is manual work in developing self-confidence and ultimate opportunity of employment for blind persons?
4. What are the indications that client did not cooperate?
5. What consideration was given to his preparation for work?

/Counseling and Planning/

REHABILITATION CLIENT NO. 9

PARTIAL CASE ABSTRACT:

Client is 59 years old, in excellent health from an organic standpoint, but with a severe psychoneurosis and a wry neck resulting from alcoholism and barbiturate habituation.

He worked as a foreman for the past 20 years for a local wax manufacturer, enjoying the confidence and respect of all who knew him. For no apparent reason he suddenly developed into a drinker. He would leave the job during the working hours and "lift 6 or 8 quick ones." He also began playing the horses, losing hundreds of dollars at a clip. Then came the barbiturates to supplement the liquor.

The head of his firm became interested and spent $3,000 trying to straighten him out, but to no avail. He was discharged after one year's hospitalization. At the time he was interviewed, he had been off both drugs and alcohol for about 5 months. He owes about $3,000, part of it on personal, unsecured loans. He is now going through bankruptcy. He wants to be rehabilitated. He wants to earn money, but because of his wry neck and age, it is almost impossible to place him. In the meantime, his wife has divorced him. He has 2 sons, 16 and 17 years of age. He has a severe sense of guilt.

DISCUSSION QUESTIONS AND EXERCISES:

1. Since it is said that this man is cured of his alcoholism and drug addiction, what is his disability? What limitations are imposed by his disability, if he has one? How are the limitations, if any, an employment handicap?

2. What specialists might be consulted in an attempt to discover his basic problem or problems? How would team evaluation help if it would help?

/Evaluation and diagnosis; Consultation/

REHABILITATION CLIENT NO. 10

PARTIAL CASE ABSTRACT:

This 41 year old man's source of income at the time of referral was Aid to the Permanently and Totally Disabled. The maximum grant was necessary to provide his care in a nursing home. The client had been run over by a car, leaving him with multiple fractures of the right leg and a fracture of the left femur. There was mal-union of the fracture of the left knee. The client needed physical therapy.

He had a second grade education. He impressed the counselor as having been through a lot of trouble but who was going to be difficult to wean away from APTD. He was receiving a grant which would probably aid him in arranging necessary physical restoration services and there was no urgency that vocational rehabilitation enter the case. However, the medical reports indicated that the client would be able to take part in light work such as sweeping, grading tobacco and other farm work. It appeared reasonable to believe that the medical information meant that the client would be able to return to a reasonable amount of work. Due to lack of education and motivation, training seemed to be very questionable in this case but direct placement in a menial job seemed possible. The case was accepted and the client is now undergoing physical restoration services through vocational rehabilitation.

The client is separated from his wife. The client has been in a nursing home since we first met him, but expects no help from his estranged wife. He also has a daughter.

A report from the client's doctors states that he probably never would be able to do work which required much standing or walking and recommends that he be trained for some sedentary occupation. Since we entered this case the medical evaluation of his work prognosis has changed for the worse. Training appears to be unpracticable. It is likely that the client has not progressed as expected and cannot be expected to walk and stand as much as previously thought possible. However, he was so severely handicapped, we had a pretty good idea that we might have a non-feasible case on our hands. He has no family resources to which he can look and will likely cling to APTD as his only source.

DISCUSSION QUESTIONS AND EXERCISES

1. Using this case as presented, rewrite the diagnostic summary in accordance with previous discussions of the techniques of good case recording and summarization.

/Case Recording/

PARTIAL CASE ABSTRACT:

Nineteen-year old girl, confined to wheelchair, very little use of legs and hands as a result of polio and spinal meningitis.

High school graduate one year ago. Her academic work was all done by correspondence through University Extension Division, high school average B+; wishes to be a social worker; psychological testing done, showed she is not college material - I.Q. 99. Subsequent testing showed average intelligence on Weschler-Bellevue; on Ohio State Psychological examination no sub-test scores fell below the 97th percentile and a total test percentile rank of 99 was achieved. Psychologist suggested prior acquaintance with the test as possible explanation for this high score.

An orthopedist and a neurologist agreed that social work was beyond client's possibility due to her handicaps; counselor informed client and her parents that test results indicated that college work was beyond the ability of the girl and suggested a commercial course, which was recommended by the psychologist. This was refuted by both parents and client, who insisted on going to a University. Rehabilitation counselor suggested that she visit the school to see what special provisions were made for paraplegics and that if the University would accept her, he would be willing to submit a plan.

Client has been taking correspondence courses through this University in history and has received a grade of B; rehabilitation supervisor of the college informed vocational rehabilitation that they would accept her for the September term.

DISCUSSION QUESTIONS AND EXERCISES:

1. List all the facts from the information contained in this case, which would provide a valid basis for counseling and planning.

2. Evaluate the consistency of the conclusion that the objective of social work is beyond the client's ability.

3. Assuming that a university course is beyond the mental capacity of this client, how would you counsel with this client? (How would you counsel with a client who has unrealistic goals?)

/Evaluation and diagnosis; Counseling and planning/

577241 O-61-13

PARTIAL CASE ABSTRACT:

A 33 year old man sustained a 10% permanent total disability while on job as a welder in construction work. He was injured by a heavy object falling on his shoulder and a third degree burn on the right upper arm and chest.

During his hospital stay, plastic surgery was performed on the chest and physical therapy was given for the shoulder and arm. The latter was continued on an outpatient basis after he left the hospital. After the healing period, medical specialists suggested that he return to employment. He was told that the residual weakness to the right shoulder and arm might partially handicap him for life but that there was a possibility that normal activity would gradually but substantially reduce the disablement.

Eight months after the accident, the man returned to his former job. He has been steadily employed as a welder for the past 16 months. His employer speaks highly of him and of his ability to do a good job.

However, the 35 year old worker requests vocational rehabilitation services on the basis that he is handicapped in doing overhead welding and that the hoped for return of strength to the affected shoulder and arm has been negligible. He does not believe that he will be able to continue welding for an indefinite period because of his condition. He has requested a vocational diagnosis and appropriate vocational training.

DISCUSSION QUESTIONS AND EXERCISES:

1. What information other than medical reports would be necessary to determine eligibility for vocational rehabilitation purposes? Where could information of this type be obtained?

2. How might a counselor go about resolving conflicting evidence of work competence as between the employer and the employee?

3. To what extent is the counselor in this case responsible for trying to direct this individual into types of welding he can do without tiring?

/Case Study; Evaluation and Diagnosis/

PARTIAL CASE ABSTRACT:

Client was referred by the City Welfare Department. He is 34 years of age. According to the general medical examination, the diagnosis of client's disability is as follows: Duodenal ulcer with symptoms thereof, nervousness. Survey information indicates that client was hospitalized 15 days for ulcer surgery. Client has an 8th grade education, part of which was obtained by attending a school for the mentally retarded.

At the date of contact client was on public welfare and was divorced. Client has a stepfather, age 59, who is unemployed, and a mother, age 52. Previous employment consisted of coal passer on lake boat 10 years, laborer scrap iron yard 1 day, and bread wrapper 2 weeks. General medical indicates limitation in stooping, straining, and work in high places.

On the basis of survey information and the general medical, a plan was developed for vocational training in welding. The plan was disapproved by the district supervisor who stated that he wanted more evidence concerning substantial employment handicap. Psychological testing was then given which indicated intelligence score of 67 on the Wechsler-Bellevue scale. Psychological report also indicated that client is unstable, is an extreme hypochondriac, is a high grade mental defective, is resentful toward his stepfather and probably needs a suitable substitute father.

DISCUSSION QUESTIONS AND EXERCISES:

1. What are the inadequacies involved in the diagnosis as shown by the counselor's submission of the plan which was disapproved?

2. What did the psychological testing report add to a more complete understanding of the problems of the client? What other areas of investigation are indicated?

/Case Study/

PARTIAL CASE ABSTRACT:

A single girl, age 17, with no dependents or immediate relatives has lived the major portion of her life in a boarding home sponsored by the Children's Aid Society. She had polio at the age of 4, has completely flail lower extremities. She walks with double braces and crutches. She has completed the 9th grade of formal education. No further medical service was recommended by the Crippled Children's Service. She has a history of syphilis in early life.

She did very good work in elementary school, fair work in junior high school, and failed most of her subjects in the 10th grade of high school. Due to her age, the Children's Aid Society were having to close their service to her. Since she was not permanently and totally disabled, there was question as to whether the Department of Public Welfare would serve her. She did not confide in anyone and appeared to have very few close friends. She was a problem to the boarding home mother as well as outright rebellious with the school authorities. She has a history of minor thievery.

On the intelligence test she functioned on the dull-normal level. Her only expressed interest was to become a secretary. Psychological tests revealed some interest in secretarial work. Our service was requested to assist her with a secretary's course at the State Vocational Trade School whereby she might become gainfully employed and self-supporting.

DISCUSSION QUESTIONS AND EXERCISES:

1. What types of information would be needed in order to reach a decision on this case?

2. What consultation would be appropriate to the gaining of a more complete understanding of the client's potentials?

/Case Study; Evaluation and Diagnosis; Consultation/

REHABILITATION CLIENT NO. 15

PARTIAL CASE ABSTRACT:

A single girl, aged 21, family dependent, graduated from high school at age 18 with an average of 72 and attended a Teachers'College for two months. She states that she left because of her health.

When about 14 years old this girl developed epileptic seizures which occurred about once a month. At the time of referral she was under medical care and taking medication but never achieved complete control. Psychometric tests indicated an I.Q. of 84 (California test of Mental Maturity). She had very poor coordination of mind and hands. Her chief interests appeared to be teaching and nursing. A plan was made to train her as an attendant nurse at a large hospital. After tentative acceptance, client was later rejected because of epileptic history.

After this rejection client expressed desire to resume teacher training at another college. She was admitted to another teachers' college on a trial basis. After a month she left because she "got nervous and confused," but President of College stated that she was unable to adjust to social and academic program, attending classes irregularly and giving little evidence of ability to do college work.

After nearly a year, client was enrolled in a correspondence course in typewriting, English and bookkeeping in conjunction with tutorial instruction. She did fairly well in typing, but the teacher said that she would never make an "all round office worker." Client gave up training because of health, claiming she heard voices and attempted suicide. Psychiatric examination revealed "psychosis with convulsive disorder, epilepsy, epileptic deterioration." Client was placed in a state hospital.

DISCUSSION QUESTIONS AND EXERCISES:

1. What are the methods for determining the appropriateness of a training situation?

2. How can a counselor be certain that medical information is adequate? When and to what extent is medical specialty consultation employed in rehabilitation case work?

3. Of what importance is motivation in the rehabilitation process?

/Case Study; Evaluation and Diagnosis; Provision of Services; Consultation/

577241 O-61-14

REHABILITATION CLIENT NO. 16

PARTIAL CASE ABSTRACT:

A 19 year old boy, single, was referred by his high school principal just prior to graduation. During the first interview, the client stated he wished assistance in the selection of a proper vocation. As a result of a congenital mid-line deformity of fusion which involves the central nervous system and face, the client has multiple disabilities. With best correction, his vision is 20/70 and 20/200 for distance and J-8 and J-18 for reading. He has marked nystagmus and congenital divergence. Coordination and finer movements of upper extremities are markedly impaired but the client has only slight difficulty in walking. It was recommended that the client not drive an automobile or work with tools around moving machinery or objects dependent upon sight.

The client had a "C" average in high school and psychological tests revealed an I.Q. to be above average. Clerical interest was high average; all other areas average with exception of the mechanical field which was low average. Mechanical aptitude tests indicated inferior mechanical aptitude. He worked slowly but his manual dexterity was rated as fair. On the clerical speed and accuracy test, he made no errors but his vision permitted him to complete only a small portion of the test. The client stated frankly that he was not too interested in attending college but would go if it seemed best or if his parents insisted. He consistently expressed an interest in some day operating a business for himself. He wished independence, financial and otherwise, from his family.

A plan was completed for the client to attend college to study Business Administration. He attended 4 quarters and during the last quarter failed in every subject. He earned a total of 35 hours with only 32 quality points. Training was terminated. He is opposed to attending business school, but still has in mind entering a business of his own even though he does not have the financial backing nor the necessary knowledge. His home situation has become unpleasant and the client has moved to the Y.M.C.A.

DISCUSSION QUESTIONS AND EXERCISES:

1. What circumstances justify the plan for college training in this case?

2. What evidence is there that the client shared in the development of a vocational plan?

3. What justification exists for the exploration of a small business opportunity?

REHABILITATION CLIENT NO. 17

PARTIAL CASE ABSTRACT:

Twenty-one year old male. Permanently blinded individual--one eye enucleated and other shrunken. Clent has slight hearing loss. Tried to fit into schools for blind in two States for elementary education, but was withdrawn from both schools because of nervousness. He seemed overly dependent on others for daily needs. Client was tutored at home and accepted as special student in regular high school from which he graduated. He has never been employed. Test results on verbal form of Wechsler-Bellevue indicate better than average verbal ability.

Rehabilitation center for the blind reports on vocational diagnostic services: has good ability to localize sounds; excellent obstacle perception. Potential for doing heavy work; good attitude; intelligent; poor personal appearance; poor physical orientation (lost in space); often becomes "turned around"; shapes and sizes are not meaningful to him tactually; things that he touches have less meaning for him than for anyone instructor has ever tested; very poor observer; does not make use of his available senses to explore the world around him; lacks initiative and thoroughness in observing; lazy, quits exercising when he begins to become a little tired; seems to have acrophobia; also has a childish tolerance for physical pain; emotionally disturbed; nervous manifestations, such as wringing hands, stuttering and eczema on hands; dependent; has not learned to take responsibility; has not learned to think and act for himself; immature. Has a tendency to live in a make-believe world; complacent; tries to "wish" things done. Coordination is poor between hands and feet; also between the two hands; no skills developed in working with things. Client cannot function under pressure of any kind; Center recommends a home study course in preparation for a college course. Client has expressed interest in ministry and in teaching.

DISCUSSION QUESTIONS AND EXERCISES:

1. What services (adjustment or others) are suggested by the vocational diagnostic study? How does one utilize the results of a client analysis by a cooperating facility?

2. What further diagnostic evaluation would you as a counselor desire?

3. What areas of case study (social, educational, emotional, etc.) would lend themselves to further development?

/Case Study; Evaluation and Diagnosis; Provision of Services/

REHABILITATION CLIENT NO. 18

PARTIAL CASE ABSTRACT:

A girl is referred to vocational rehabilitation with a left congenital club foot corrected by a series of operations. There is some atrophy of the limb and a prominent limp.

At the time of first contact, this single girl lacked three-fourth of a credit of finishing high school. Her ambition to be a nurse or a medical secretary was considered. Without training, she secured a low-paid job as receptionist for a doctor. She was married and the case closed without service.

Four years later, a divorce and 2 minor children brought home to her the need for training. In the meantime, she had worked as a telephone operator and considered objectives of x-ray technician, medical secretary, and stenographer. Client had a definite interest in the medical and technical field. She had the required mentality, good personality and ambition to succeed.

Training was arranged with an x-ray specialist, including all phases of the laboratory worker's job, without cost to the bureau. Some maintenance was provided, as her laboratory earnings were insufficient for the family expenses. A high school certificate of equivalency was secured to allow for later certification. Training progressed satisfactorily and client's wages were usually advanced ahead of schedule. Towards the end of the training program, she complained about being on her feet all day. This was easily adjusted in this large x-ray laboratory by assignment of a variety of duties during the afternoon, including the typing of records.

DISCUSSION QUESTIONS AND EXERCISES:

1. What justification exists for provision of service to a client with experience in a physically suitable occupation?

2. Discuss vocational rehabilitation's responsibility for maintaining family of client during preparation for employment.

/Determination of financial need; Evaluation and Diagnosis; Provision of Services/

PARTIAL CASE ABSTRACT:

Client is a 28 year old, unmarried male. After high school graduation he worked in an exterminating company for about 1 year before going into the Army in which he served 2 years, doing mainly clerical work. After service he worked 5 years as a laborer for a cork company. He took a laboratory technician course for 15 months, under the GI Bill and at the same time, worked part-time as a switchboard operator. Later he was employed full-time as a laboratory technician, at a salary of $250 per month, and after a year, he broke down with pulmonary tuberculosis. During hospitalization at the VA Hospital he had a resection of his right upper lobe, and when well on his way to recovery, was permitted to work in the hospital research laboratory. Upon discharge from the hospital, the doctor advised client could safely return to his previous occupation as laboratory technician. Client has been re-employed now for a year as a laboratory technician.

Client's parents, brothers and sister have had many health and family problems which have kept client from attaining his goals - medicine (more specifically, surgeon) or bacteriology.

Extensive psychological testing shows client to be of superior intelligence; his perceptual and motor skills are of an extremely high order; and "in terms of interest, personality and ability, he seems a natural for his chosen field." Client's parents are now deceased, his brothers and sisters are all grown and independent. He is now applying to vocational rehabilitation for financial assistance for training to become a doctor or bacteriologist.

DISCUSSION QUESTIONS AND EXERCISES:

1. What are the agency's responsibilities with respect to the client's hopes and aspirations?

2. Is client, without further service, at the point where he can compete with the non-disabled without disadvantage?

/Case Study; Preliminary Investigation/

PARTIAL CASE ABSTRACT:

Client is now a reopened case. Disability was polio, both legs severely affected. Client wears two full leg braces. Client is a high school graduate with a B+ average. He did art work in high school on the Yearbook. Definite natural ability but no training in art. While driving a truck, he killed a woman. The son of the woman was riding in the cab at the time. Possible psychic trauma as result. Client is intelligent, enthusiastic and very ambitious. Should be given opportunity to go to college. Interested in doing something while convalescing. Kuder Preference Record showed very high social interest, high art interests and interest in music.

Took two correspondence courses in the Elements of Drafting. He got a 95 grade in both courses. It seems the objective should be drafting. The original objective in school was drafting or art. In the meantime, client got interested in photo retouching and forgot about plans to go to college. He got a photo retouching machine and was then closed out by vocational rehabilitation. He now concludes retouching is too nerve-racking. He says it is hard on his eyesight and he can't work at it steadily enough. Also, it is seasonal. Client realizes he should have followed the original plan.

Psychological testing indicates the following: Wechsler-Bellevue Verbal I.Q. - 117; Performance I.Q. - 126; Full Scale I.Q. - 124. Superior general intelligence. Unusual amount of ability in art and drawing. Fortunate personality, sincere, poise. Client realistic about handicap. Three careers possible - Engineering (Architecture, etc.), Photography and teaching.

DISCUSSION QUESTIONS AND EXERCISES:

1. Under what conditions may a client be given services to become more suitably employable?

2. What steps should be taken to verify a client's complaints or dissatisfaction?

3. Is client without need of further service, at the point where he can compete with the non-disabled without disadvantage?

/Case Study; Evaluation and Diagnosis/

REHABILITATION CLIENT NO. 21

PARTIAL CASE ABSTRACT:

Client referred by private agency. Eye report received. O.D. 8/200, retinal detachment. O.S. no vision, complicated cataract. Should avoid lifting, stretching, pushing, pulling, stooping. Travels alone with cane, can read Braille, Grade II, can detect color faintly, can read headlines with magnifying glass. There are no limitations other than blindness, ventricle slightly enlarged to the left resulting from a heart attack in 1953. Doctor states he has apparently made a complete recovery. Client's blindness constitutes a vocational handicap which requires change in equipment so that he will be able to perform.

Client has degress in English literature from 3 universities. Client's main employment has been in writing, copywriting and allied research. His job, which is being held open for him, is with an advertising firm. This job paid $7,700 per annum. Client is a 53 year old married male, living with his wife, who is a housewife. He is an attractive-looking, tall, stately gentleman with a very polished pedagogic air. Client is extremely polite, unassuming and direct. He states he has made adequate adjustment to blindness and heart condition, which is corroborated by his doctor.

Client states his old position is being held open if he can demonstrate that he is capable of doing the work. He was research director at a financial advertising and public relations agency. His work involved copywriting for advertisements. Client states that he will need some type of recording machine in order to make adjustment to his former work. A machine with a disc record is preferable to a wire or tape recorder. Client is now trying out a recording machine on a 90-day trial basis. Client feels he will need 2 recording machines, 1 for home and 1 for office use. Statement to be secured to determine economic need. Details of job to be discussed with client in order to make useable suggestions for working out vocational problems.

DISCUSSION QUESTIONS AND EXERCISES:

1. What further medical study, if any, is indicated?
2. What facts show presence or absence of an employment handicap?
3. How does this case illustrate the importance of the principle of need for careful matching of capacities and limitations with job conditions?
4. What arguments can be advanced for and against having the client or the employer meet the cost of the recording devices?

/Case Study; Evaluation and Diagnosis; Provision of Services/

SUGGESTED TEACHING POINTS FOR WHICH THE CASE ABSTRACTS MAY BE UTILIZED

Case Abstract No.	Teaching Points
1	Criteria of "substantial employment handicap" Determining financial need in individual cases Eligibility for vocational rehabilitation versus eligibility for a "specific service"
2	Outside of vocational rehabilitation dictation in acceptance of cases and provision of services Acceptance of a case for "specific service or services"
3	Diagnosis based on adequate case study Motivation
4	Vocational rehabilitation services must be related to job objective Disability versus handicap
5	Exercise in selecting areas of case study (following initial interview) Standards for considering dental disorders as an employment handicap
6	Elements involved in a statement of eligibility (or ineligibility) where no previous work experience is presented in the case.
7	Circumstances under which personal adjustment counseling is indicated (developing self-understanding)
8	Personal adjustment to blindness Transitional employment as a means of preparation for final job adjustment
9	Utilization of consultation Recognition of motivation Reasonable expectation of satisfactory outcome in cases of drug and alcohol addiction
10	Case recording techniques
11	Techniques of counseling with respect to unrealistic objective Development of rehabilitation diagnosis and prognosis

Case Abstract No.	Teaching Points
12	Evidence of employment handicap
13	Reason for medical evaluation - employment limitations Employment handicap
14	Psychological, psychiatric development
15	Counselor recognition of the need for consultation Need for medical stabilization
16	Directive versus non-directive counseling
17	Personal adjustment service Incomplete diagnosis Psychiatry as a resource
18	More suitably employable considerations in determination of eligibility Family need versus client need
19	Equal opportunity as a goal of rehabilitation More suitably employable - eligibility
20	More suitably employable - eligibility Equal opportunity as a goal of rehabilitation
21	Job analysis Furnishing of occupational equipment - relative responsibilities of employer, client and rehabilitation agency.

APPENDIX II

GUIDELINES FOR COUNSELOR IN-SERVICE TRAINING

The committee on the in-service training of new counselors of the Thirteenth Guidance, Training, and Placement Workshop, proposed some guidelines useful to State rehabilitation agencies both for orientation and continual in-service training. The committee's report is quoted in full for use by State agency personnel concerned with such programs.

Basic Assumptions

1. It is assumed that training starts the day a counselor goes to work for an agency and continues in one form or another, as long as he remains an employee of the agency.

2. It is assumed that orientation training refers to the training provided during the first few months and is an essential part of the agency's long-term in-service training program.

3. It is assumed that each State agency is committed to a program of continued in-service training in order to insure the development and growth of professional competencies of its staff, thus assuring that sound professional services are provided to its clients.

4. It is assumed that the training needs of each counselor will vary, dependent upon the appreciations, knowledges, skills, abilities and experiences that he possesses when he enters employment with the agency; and that the content, method, and nature of an agency's in-service training program will be designed to meet individual needs.

Objectives

The committee accepts the six objectives of orientation training as listed on page 44 of Part II of the Report of Proceedings of the Seventh Annual Workshop on Guidance, Training and Placement (1954) with slight modifications. They are as follows:

1. To provide the counselor with an understanding and appreciation of the broad principles underlying vocational rehabilitation.

2. To acquaint the counselor with the historical background of the vocational rehabilitation program, its legal basis and its regulations and policies.

3. To provide the framework for an understanding of his duties and responsibilities in relation to agency procedures; and to make the counselor skillful in the performance of those duties.

4. To familiarize the counselor with the facilities available to him for supervisory assistance, consultation, and client services.

5. To stimulate in the counselor a feeling of "belonging" to a professional group that functions cooperatively in serving eligible clients.

6. To make the counselor aware of the need for continuous professional growth and development in order to keep abreast of the latest methods and techniques in vocational rehabilitation.

Outline for In-Service Training

On the basis of the above stated basic assumptions and objectives, the committee recommends the following:

A. General orientation

1. Personnel
2. Organization of the agency
3. The agency operation
4. Familiarization with policy and procedures through
   a. State plan
   b. procedures manual
   c. departmental or similar handbooks
   d. annual reports
   e. professional publications
   f. reference library list such as "Selected Bibliography for Counselors"
   g. directory of service agencies
   h. Office of Vocational Rehabilitation Manual
   i. copy of Federal Laws (P.L. 565 and Regulations)
   j. medical dictionary
   k. description of common impairments
   l. Office of Vocational Rehabilitation Service Series publications including
      (1) Casework Performance in Vocational Rehabilitation, a compilation of GTP material edited by Bruce Thomason;
      (2) Psychological Services in Vocational Rehabilitation, by Salvatore DiMichael;
      (3) Psychological Aspects of Physical Disability, edited by James F. Garrett;
      (4) Orientation and Training Manual for Vocational Rehabilitation Counselors, edited by John McGowan.

      The bulletins to be prepared during this fiscal year:

      (1) Placement Aspects of Rehabilitation Counseling, edited by Bruce Thomason;
      (2) Vocational Rehabilitation of the Mentally Retarded, prepared by William Fraenkel of the National Association for Retarded Children.

The following publications planned for the future:

(1) Staff Supervision in Vocational Rehabilitation;
(2) Rehabilitation of the Handicapped in Small Business Enterprises;
(3) Diagnostic and Evaluation Guides for Selected Disability Groups.

B. Selected field experiences

1. Field observations
2. Case reviews (closed rehabilitated, active, etc.)
3. Interview techniques
4. Supervised field practice
5. Introduction to referral sources
6. Introduction to rehabilitation resources

C. Specific areas of training

The committee recognizes that certain training material related to counselor needs can best be presented at scheduled regional orientation training institutes. As a general rule, these would include material designed to develop broad understandings, background knowledges and general concepts. On the other hand, material and experiences aimed at developing specific skills and job effectiveness related to professional competencies are generally best provided at the State level. A general outline for such a program is provided below.

State Orientation	Regional Orientation
1. Extent and Problems of Disability	
State figures	U. S. figures
State figures on specific disabilities	National trends
State trends in disease and injuries	National trends in disease and injury
Economic changes and shifts in population	National trends in laws and regulations
2. Society's Organization to Meet the Problem	
Statement on State's Changing Concepts of Society's Responsibility for the Individual	Statement on Changing Concepts of Society's Responsibility for the Individual
Identify State Counterparts (Public and Private)	National Programs (Public and Private Agencies)
State VR Relationships	Education and Research
Other Resources and Facilities	Legislative Development in Services to the Handicapped
State Legislative Trends in Development of Services to the Disabled	

3. Basic Concepts of Rehabilitation

State's Philosophy of Rehabilitation
Extent and Type of Services
Individual Responsibility
Vocational Rehabilitation
Influence of Individual Differences and Capacities

4. The Vocational Rehabilitation Counselors Job

Role of the Counselor in State VR Program
Extent of Responsibility and Authorized Public Relations
Relations with Private and Public Agencies
Formal Agreements
Sources of Referral
Preliminary Screening and Selection

Vocational Rehabilitation Client Study
- A. Intake (Selection and Preliminary Client Study)
- B. Medical Evaluation
- C. Social Evaluation
- D. Psychological Evaluation
- E. Educational Evaluation
- F. Vocational Evaluation

Rehabilitation Diagnosis
Planning of VR Services

Role of VR Councelor in the Rehabilitation Process
Fundamental Concepts of the VR Counselor's Role
Fundamental Concepts of Vocational Rehabilitation Process
Vocational Rehabilitation Client Study

- A. Intake (Selection and Preliminary Client Study)
- B. Medical Evaluation
- C. Social Evaluation
- D. Psychological Evaluation
- E. Educational Evaluation
- F. Vocational Evaluation

Rehabilitation Diagnosis
Planning of VR Services

5. Utilization of Community Resources in VR Related to Rehabilitation Study, Diagnosis and Planning

(Utilization of State counterparts of opposite resources.)

1. Health and Medical Facilities
2. Welfare
3. Educational
4. Training
5. Employment

(Note: It is recommended that principles and practices in counseling and recording techniques be integrated throughout the presentation of process material.)

Schedule for Continual In-Service Training

The report up to this point has been concerned with presenting general assumptions, statements of purpose, and a broad general outline for

the training of new counselors. We have been primarily concerned with that phase of the total in-service training program known as orientation training. The remainder of this report will present suggestions for the general program of continual in-service training which follows orientation training and continues throughout the counselor's employment.

The program needs to be planned in such a way that it will aid the counselor and his supervisor in an evaluation of the counselor's training needs, with the aim of assuring his professional growth and development.

In attempting to present such material no one method or technique is necessarily better than any other, and oftentimes a combination of various methods and techniques is the best. The following general methods seem appropriate: conference, institutes and workshops, selected readings, extension and correspondence courses, formal academic training and seminars.

A brief discussion of each technique, and its advantages in terms of content presentation is presented below:

Conferences: The conference technique seems applicable in dealing with problems related to: inter and intra-agency communications and understandings; rehabilitation problems of mutual interest to agencies;--when the active participation of counselor and related agency worker is desirable. This would include such agencies as: Employment Service, Crippled Children's Division, Department of Welfare, etc.

Institutes and Workshops: The institute or workshop is an appropriate technique for short intensive work conferences involving staff participation because it affords an effective means of problem solving and staff development. The effectiveness of the workshop can be enhanced by use of consultants who are specialists on the subject under consideration. It is the responsibility of the agency to instruct the specialists in their functions and responsibilities in order to make maximum use of their services.

Selected Readings: A list of selected readings should be developed based on counselors' needs and interests as developed through supervisory conferences.

Extension and Correspondence Courses: Agencies should be encouraged to affiliate and cooperate with the existing State or private colleges' and universities' extension or continuing education departments with the purpose being to work out courses to be given by their department which would be of extreme value to agency personnel either on residency or correspondence basis. As a general rule the director of the continuing or extension division is in a better position to organize such a course than is a department chairman.

Formal Academic Training: This method of training is recommended for developing basic competence as a rehabilitation counselor. This

training may be directed toward a special area of counselor development and may lead to a higher academic degree. Educational leave, part-time employment, stipends, adjustment in hours and schedule of work, together with other agency encouragement should be extended to the counselor to assure successful completion of this type of training.

Seminar: This technique of instruction seems most applicable in dealing with problems that require special research or study, or closer interaction between instructor and class than is usually found in a formal academic class setting. It is useful in presenting such problems as special counseling problems in rehabilitation counseling; physical functioning capacities of cardiac clients; use and interpretation of personality tests with the physically handicapped, etc. Seminars can either be developed through the use of agency supervisory personnel or regular university staff in such a manner as to tailor the course to the specific needs of the counselors.

In summary, continual in-service training is essential for the professional growth of a vocational rehabilitation counselor. Each State agency has the responsibility of providing opportunities for such training regardless of the method or methods used.

The material presented in this report is intended to serve as a general outline for such training, but each State will need to modify and supplement this outline in order to meet problems unique to its staff.

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